

DRAFT
Provider Policy Manual
State of Tennessee
Department of Children's Services

July 1, 2008

Note to Users:

The core standards described in SECTION ONE apply to every agency regardless of the population of children and youth they serve. SECTIONS TWO through EIGHT outline the levels of care available to children and youth through contractual relationships between the State of Tennessee's DCS and private provider agencies. These Sections are subdivided by type of program and describe the requirements that apply to those agencies serving that specific population of children and youth. These Sections serve to inform agencies of DCS policies as well as to insure that the children and families served receive quality services so that timely permanency is achieved. SECTION NINE contains attachments including a listing of applicable DCS policies, forms and other guides. SECTION TEN is the Glossary.

Within each level description, the reader will find a definition of the service and placement type, the admission/clinical criteria, and the service components required within the per diem. (The only level of care not detailed to this extent is the Unique Care Agreement.) The Manual user will find hyperlinks to mandated DCS Policy. By the next update, all levels will carry the same format and topics as can currently be found in Foster Care. Also, please note that in some cases entire sections of the previous version of the manual have been removed and replaced with the DCS hyperlink. As updates are made, there will be other sections that will be treated the same way.

As stated in each private provider agency's contract, the agency is subject to monitoring and evaluation by all appropriate State entities and is bound to all requirements outlined in this manual.

To the best of our knowledge, all relevant DCS policies have been cited and the information contained within the Manual is accurate and consistent; however, DCS Policy takes precedence over any discrepancies which might be contained within the Provider Policy Manual. All DCS policies can be referenced through the following link:
<http://www.state.tn.us/youth/dcsguide/policies.htm>

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SECTION TEN

GLOSSARY

SECTION ONE

CORE STANDARDS

I. Organizational and Administrative Requirements

A. Agency Purpose

1. The agency has a defined purpose and administers services responsive to the needs of individuals, families, and groups served by the agency.
2. The agency maintains a written statement of its purpose that is reviewed by its voluntary board at least every four (4) years in light of changing community needs, service techniques, and consumer demands.

B. Organization

1. The agency is legally authorized to operate in one of the following ways:
 - a. as a not-for-profit agency, incorporated in the state or province in which it operates, with a charter, constitution, and bylaws
 - b. as a not-for-profit agency with its own governing body that is organized with an identified agency of a religious body with legal status or is an identified agency or another legal entity that is recognized under the laws of the state or province
 - c. as a public agency authorized and established by statute or a subunit of a public agency with which a clear administrative relationship exists
 - d. as a proprietary agency organized as a legal entity as a corporation, partnership, or association, but excluding sole proprietors, and which has a charter, partnership agreement, or articles of association and a constitution and bylaws
2. The corporation's constitution and bylaws, the partnership agreement, or the agency's written operational procedures in the case of a subunit of an organized legal entity describe the organizational structure and responsibilities of the governing body and/or of the advisory board, as appropriate.
3. The agency operating as a not-for-profit corporation maintains a record of the ownership of all its properties and monitors the financial transactions entered into with respect to these properties to assure that board members, personnel, or consultants are not in a position of conflict of interest and do not use their agency relationship for personal gain.

C. Governance

1. The agency has a governing body responsible for establishing its policies,

defining its services, guiding its development, and assuring its accountability to the community.

2. The governing body exercises its responsibility for overall direction of the agency's program of services by formulating its policies and evaluating these policies at regular intervals.
3. In the case of a public agency with an elected or appointed governing body or in the case of a proprietary agency where the owners and/or directors serve as the governing body, the governing body has appointed one or more voluntary advisory boards or has developed other voluntary mechanisms to assure the meaningful participation of the public in needs assessment, planning, evaluation, and policy development.
4. Board members receive formal orientation as appropriate to the agency's structure, goals, objectives, and methods of operation; are familiarized with the activities of its program by visiting the agency; and are provided with a board manual.
5. The members of the governing body or advisory board of a voluntary or public agency have no direct or indirect interest in the assets or leases of the agency. Any member who individually or as a part of a business or professional firm is involved in other business transactions or current professional services of the agency shall disclose this relationship and shall not participate in any vote taken in respect to such transactions or services.
6. The minutes of the advisory and/or governing bodies are maintained, organized, and kept as a permanent and up-to-date record and include dates of meetings, names of participants, issues covered, and actions taken.
7. The agency does not have an owner, member of its board of directors, or member of its board of trustees who holds any other positions that may influence the placements provided to foster children.
8. Advisory board members of proprietary agencies have no direct or indirect financial interest in the assets, leases, business transactions, or current professional services of the agency and are restrained from having same by written agency policy.

D. Regulatory Compliance

1. The agency is duly licensed and in good standing to operate its program of services and legally established to provide services.
2. Licenses or other evidence of compliance are prominently displayed.
3. The agency purchases services only from agencies that are in compliance with

the standards established by the state or provincial body having licensing or regulatory authority for the service under consideration and, where possible, uses an agency, institution, hospital, or clinic accredited by a national accrediting body in making such arrangements.

4. The agency is in full compliance with federal, state, provincial, or local fire safety codes and regulations. Where these codes are in conflict, the more restrictive codes apply.
5. The agency's buildings and grounds, offices, equipment, and other structures conform to applicable zoning and building codes.
6. The agency's food service, plumbing, ventilation, heating, cooling, lighting, elevators, and other fixtures and equipment conform to all health, sanitation, and safety codes and regulations.
7. The agency complies with all health regulations and codes applicable to its program personnel.
8. The agency maintains in its permanent file the reports of insurance; inspections; occupational safety and health administration reports; incident reports; reports of health, fire, and safety inspections; and reference copies of applicable regulations.

E. Agency Administration

1. The administration of the agency is the responsibility of the chief executive officer. The chief executive officer plans and coordinates with the governing body or its advisory board the development of policies and procedures governing the agency's program of service.
2. The chief executive officer's responsibilities include the development, coordination, and administration of the agency's program of services and its financial and personnel resources.
3. Clear lines of accountability and authority exist at all levels of the agency's organizational, administrative, and service structures and are presented in writing on a current table of organization or other written plan for lines of accountability so that all personnel have been formally oriented.
4. In the case of a subunit of a public agency or an agency with another recognized legal entity serving as a parent organization, a clear administrative relationship with the parent organization exists and responsibilities are delegated to and executed by the appropriate levels of the organizational structure.
5. The agency has a manual containing the essential policies and procedures for

effective service delivery and protection of client's rights, provides a copy of this manual upon employment of new personnel, and keeps all personnel up-to-date on revisions of the manual.

6. The agency policies and procedures are available for the guidance of the governing body; agency personnel; licensing, accrediting, or funding bodies; and other interested groups or individuals.
7. High standards of ethical conduct govern board members and personnel in operating the agency's services and representing it to the community. The agency has (or, as in the case of a subunit of a larger entity, is subject to) written policies governing ethical conduct of its programs and operations including conflicts of interest.
8. Employees and paid consultants of a voluntary or public agency have no direct or indirect financial interest in the assets, leases, business transactions, or professional services of the agency and are restrained from having same by written conflict of interest policies.
9. The agency seeks to protect its clients and its physical, personnel, and financial resources through a process of evaluating and reducing the risks to which they are exposed. The agency coordinates its efforts to manage and reduce risks with its overall quality assurance program.
10. The agency carries worker's compensation insurance and such other insurance as is deemed necessary based upon its evaluation of its risks.

F. Quality Assurance/Utilization Review

1. The agency has an ongoing quality assurance program in which each service of the agency and service to individual clients is regularly reviewed and monitored in order to promote the highest quality service, to resolve problems that are identified, and to assure that services meet the agency's expectations as to outcome.
2. The overall scope of the quality assurance program is described in a written plan or outline that describes mechanisms, committees, or other methods used to coordinate the agency's approach to monitoring and evaluating the quality and appropriateness of service.
3. The agency sets goals and objectives for the benefits or outcomes to be achieved by clients who use the agency services, and on a regular basis the agency conducts client satisfaction surveys or utilizes other methods of determining the outcome of its services, including the reasons for termination of clients who drop out of service, to the extent this can be ascertained.

4. The agency regularly monitors the quality of care and reviews the appropriateness of service.
5. The agency has a system of client service monitoring that ensures that the cases of all clients are formally reviewed on a periodic basis and that, depending on the type of service, may be supplemented by utilization review or other quality assurance mechanisms.
6. The agency shall participate in utilization reviews at least every 90 days as initiated by the Department. Utilization reviews are to include regional UR representatives (these are usually the Resource Placement Specialists in the region) to evaluate the necessity, appropriateness, quality, and intensity of individual client services to facilitate permanency and most appropriate setting for service delivery as soon as possible. The utilization review focuses on appropriateness and effectiveness of client services, and reduction of length of stay in out-of-home care. Measurable criteria are utilized in the review process, extended treatment or service, changes in status or level of need presented by the client, and/or other criteria developed by the agency.
7. The agency must participate fully with Program Accountability Review monitoring.
8. The agency cooperates with authorized external review systems (including juvenile courts) and, where applicable and where possible, organizes its internal review schedules to complement those conducted by external review systems.

G. Fiscal Management

1. The agency has a written budget that serves as the plan for management of its financial resources for the program year and that enables it to carry out its program.
2. The agency is committed to public disclosure and prepares and makes available an annual report of fiscal, statistical, and service data that includes summary information regarding the agency's financial position.
3. A certified audit of the proprietary or voluntary agency's financial statements is performed within the following year by an independent certified public accountant approved by the governing body.
4. The agency adheres to the state's reimbursement reporting procedures.
5. The agency that provides services as a vendor establishes safeguards against over- and under-billing that could jeopardize future funding or weaken the agency's financial conditions.

H. Subcontracting

1. The agency that engages in contractual agreements as a purchaser or vendor of services complies with state requirements for subcontracting.
2. Subcontracts (SC) are between a contractor, who has entered into a fully executed contract with the Department of Children's Services (DCS) to provide a specific service(s) and referred to in that executed agreement as the "contractor," and a freestanding agency, hereinafter known as the "subcontractor." The purpose of a subcontract is to secure a service that is not provided by the contractor. Subcontracts can also be between a contractor and an individual to provide a specific service (i.e., psychiatrist to provide therapy/counseling).
3. Providers using subcontractors for providing any type of direct services to children and/or families will develop a written master subcontract describing how the services are to be used and monitored with documentation of monitoring. Contractors using subcontractors for providing any type of direct services to children and/or families will utilize the Master Subcontract Template provided by the Department of Children's Services Contracts and Grants Management Unit. The contractor with whom DCS has contracted directly shall remain the prime contractor and shall ultimately be responsible for all work performed.
4. The contractor is responsible for the monitoring of the subcontractor. All subcontractors must meet state licensing requirements and hold a valid license for the period of the contract. See how to subcontract for services on the DCS Web site or contact DCS directly by phone or e-mail.
5. No placements and/or use of the subcontractor are permitted prior to an explicit written approval from DCS Contracts and Grants Management Unit.
6. An Individual Service Agreement (ISA) is an individualized agreement that specifically details the needed services for the child, the type of service, the level of care, per diem rate, and how many days the child is expected to receive that care/service. The need for an ISA occurs in a continuum of care when a contractor cannot or does not offer the level or the type of service needed for the child's plan for permanency. The original contractor may need to subcontract with another provider or an individual to provide those direct services to the child and/or family. After the contractor and the subcontractor receive written approval from DCS, an ISA will be required for each child who needs the subcontractor's direct services. See Individual Service Agreement Guidelines on the DCS provider Web site at www.state.tn.us/youth/providers/index.htm.

I. FUNCTIONAL SAFETY

1. The agency acts to ensure the functional safety of its clients, personnel, and visitors.
2. The agency conducts a program of regular inspection and preventive maintenance to ensure the soundness and safety of its premises, equipment, and fixtures.
3. The agency has a written plan for dealing with fire, medical emergencies, or natural disasters and other life-threatening situations
 - a. in keeping with the needs of the client group served by the agency;
 - b. detailing evacuation procedures and appropriate responses to medical emergencies; and
 - c. to which personnel are formally oriented.
4. The agency that administers medication to clients establishes controls governing proper administration and storage that include
 - a. locked storage with supervision and access by authorized personnel;
 - b. proper labeling, with name of client, dosage, and name of medication;
 - c. name of prescribing physician, and number or code identifying the written order; and
 - d. destruction of out-of-date medication or medication prescribed for former clients.
5. When the agency prepares food, the storage, preparation, and service areas are in compliance with local sanitation codes and/or food-handling regulations.

J. SPECIAL HEALTH PRECAUTIONS

DCS Policy 20.19 Communicable Diseases,

<http://www.tennessee.gov/youth/dcsguide/policies/chap20/20.19CommunicableDiseasesApr07.pdf>

DCS Policy 20.22 HIV and AIDS

<http://www.tennessee.gov/youth/dcsguide/policies/chap20/20.22%20HIV%20and%20AIDS.pdf>

1. The agency undertakes additional health and safety precautions as indicated by client need.
2. The agency that provides any form of child care (day program for young children) or treatment, home care, residential group care, or foster care develops procedures for the maintenance of a safe, hygienic, and sanitary environment and monitors adherence to those procedures.

3. The procedures address
 - a. the potential for the spread of infection in bathrooms, bedding, food preparation areas, and in handling of sick children or adults;
 - b. storage of cleaning supplies and hazardous materials, including medication, in a safe location; and
 - c. maintenance of a hazard-free environment in facilities through regularly checking water temperature, covering electric outlets, securing floor covering or equipment, and reviewing the adequacy of lighting and ventilation.
4. Dietary services, when provided as part of a service offered by the agency
 - a. meet national nutritional standards;
 - b. are planned;
 - c. meet general and prescribed dietary needs;
 - d. take into account racial, cultural, ethnic, and religious variations in eating habits; and
 - e. provide appealing, well-balanced meals and snacks according to the posted menus.

K. PHYSICAL ENVIRONMENT AND EQUIPMENT

1. The agency is housed, equipped, and maintained in a manner that is suited to its program of services and that reflects the agency's positive regard for its clients.
2. The physical environment is consistent with contemporary, accepted concepts of service and care and is one that enhances individual dignity and feelings of self-worth for the clients served.
3. The agency allocates sufficient space and safe and varied equipment for outdoor play to meet the children's recreational needs.
4. Offices or rooms are available to personnel to engage in interviewing or counseling families and children in a private and confidential manner.
5. The agency provides access to up-to-date professional and program information by
 - a. maintaining a library or collection of professional periodicals, standard references, and community information; and
 - b. arranging for personnel to have ready access to a nearby information resource.

L. TRANSPORTATION AND VEHICLE MAINTENANCE

1. All vehicles must be maintained and operated in a safe manner. (This includes the vehicles owned by the facility and/or by an employee if the employee provides transportation in his/her privately owned vehicle.)
2. The agency provides adequate passenger supervision, as mandated by level of care.
3. All facility-owned and staff-owned vehicles used for transportation of children/youth **must be adequately covered by medical and vehicular liability insurance** for personal injury to occupants of the vehicles. Documentation of such insurance coverage must be maintained in the facility's records.
4. Staff and resource parents providing transportation must possess a valid driver's license. Documentation of the license is to be maintained in the facility's records and validated annually.
5. All facility-owned and staff-owned vehicles used for transportation of children/youth have a current registration and inspection, as required by the county of residence.
6. Appropriate safety restraints must be used as required by state and federal law.
7. The agency maintains the primary responsibility for providing transportation to children in the program including transportation to all medical/dental appointments, court appearances, emergency transportation, and transportation to family visits. The agency may request that the FSW apply for flexible funding in order to assist with transportation costs. Transportation that exceeds 150 miles round trip from the agency site must be approved/disapproved in the CFTM process.
8. TennCare transportation cannot be used for children in custody.
9. No children in custody shall access public transportation unless supervised by a DCS or a provider agency staff person or designee. Children in custody who wish to travel alone may receive prior approval to use public transportation via a CFTM. This approval as well as any designated persons shall be documented in the child's TNKIDS case recordings. A copy of the written approval is kept in the child's case file.

M. NONDISCRIMINATION

<http://www.tennessee.gov/youth/dcsguide/policies/chap24/24.10TitleVIProgramandComplaintProcess.pdf>

1. The agency assures that no person shall be excluded from participation, denied

benefits, or otherwise subjected to discrimination in the performance of the services or in employment practices on the grounds of disability, age, race, color, language, religion, gender, national origin, or any other classification protected by federal, Tennessee state constitutional, or statutory law.

2. Written agency policy assures that need for the agency's services is the primary criterion of eligibility and its services are offered without discrimination.
3. The agency has a written equal opportunity policy that clearly states its practices in recruitment, employment, transfer, and promotion of employees.
4. The agency actively recruits, employs, and promotes qualified personnel broadly representative of the community it serves and administers its personnel practices without discrimination based upon age, sex, race, ethnicity, nationality, handicap, or religion of the individual under consideration.
5. The agency provides for internal and external dissemination of its equal opportunity policy and recruitment materials that specify the nondiscriminatory nature of the agency's employment practices.
6. If the agency recruits and selects with regard to specific characteristics, it does so with the needs of the agency's defined clientele in mind and in accord with exemptions in the law(s) governing equal opportunity employment.
7. The agency shall show proof of nondiscrimination and post in conspicuous places, available to all employees and applicants, notices of nondiscrimination.
8. The agency has among its facilities some that are free of those architectural barriers that restrict the employment of or use by physically handicapped personnel. Likewise, the agency has among its service facilities some that are free of architectural barriers that restrict use by the aged, families with young children, and handicapped persons and/or makes provision for use of accessible facilities in order to provide services to handicapped persons.

N. CONFIDENTIALITY

DCS Policy 9.4 Confidential Child-Specific Information

<http://www.tennessee.gov/youth/dcsguide/policies/chap9/9.4%20Confidential%20Child-Specific%20Information.pdf>

DCS Policy 9.5 Access and Release of Confidential Child-Specific Information

<http://www.tennessee.gov/youth/dcsguide/policies/chap9/9.5%20Access%20and%20Release%20of%20Confidential%20Child-Specific%20Information.pdf>

1. Strict standards of confidentiality of records and information shall be maintained

in accordance with applicable state and federal law.

2. The agency and release of information about its clients, and assures itself that such policies meet any applicable legal requirements. Written policy specifies the responsibility of all personnel for maintaining confidentiality of information contained in client and personnel records.
3. Access to records is limited to the client, the parent or legal guardian when the client is a minor, authorized agency personnel, and others outside the agency whose request for information access is permitted by law and is covered by assurances of confidentiality and whose access is necessary for administration of the agency and/or services to the client.
4. A release of information must be obtained prior to sharing information in any situation other than that described above.
5. A client may review his/her record in the presence of professional personnel of the agency on the agency premises, and such a review is carried out in a manner that protects the confidentiality of other family members and other individuals whose contacts may be contained in the record.
6. All client information is kept in a locked, secure place.

O. HIPAA COMPLIANCE

1. Pursuant to the provider's contract with DCS, the contractor must be familiar with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its accompanying regulations and must comply with all applicable HIPAA requirements in the course of the contractual relationship.
2. The contractor agrees to cooperate with DCS in the course of performance of the contract so that both parties will be in compliance with HIPAA including cooperation and coordination as necessary with state and DCS privacy officials and other compliance officers required by HIPAA regulations. The contractor agrees to sign any documents that are reasonably necessary to keep the state, DCS, and the contract provider in compliance with HIPAA, including but not limited to business associate agreements, if deemed appropriate.
3. Ongoing monitoring of compliance with HIPAA privacy policies is the responsibility of DCS.
4. Information on HIPAA compliance can be found in DCS Chapter 32, HIPAA Policies and at www.state.tn/youth/dcsinfo/hipaa.htm.

P. EXPANSION OF SERVICES PROTOCOL

Residential Congregate Care Treatment Facility and /or Group Home

The Department of Children's Services, Office of Child Permanency, Child Placement and Private Providers (CPPP) Unit is the division responsible for coordinating, analyzing and facilitating the expansion/reduction of services within the provider network. In accordance with Finance and Administration (F&A) rules, the Department procures all residential services through a Delegated Authority (DA). The DA clearly defines the process through which services can be procured. In order to maintain compliance with these rules, the Department has established the following guidelines for providers to follow when seeking to expand their congregate care treatment facility or Group Home service capacity:

- ☐ Providers **do not** have the authority to expand their capacity (residential Group Home or congregate care treatment facility service) to serve **DCS CUSTODIAL CHILDREN OR YOUTH** without first consulting the appropriate DCS division (CPPP) and receiving prior written approval from the Department.
- ☐ The issuance of a license for a congregate care treatment facility or Group Home by any licensing agent (DCS, MHDD, and/or DOH **does not** constitute approval from DCS to accept or place custodial children with any newly-licensed Group Home or other congregate care treatment facility.
- ☐ All providers interested in expansion of **residential** congregate care treatment facility or Group Home services **MUST** contact the Director or Assistant Directors of CPPP in writing on official agency letterhead. This correspondence must be signed by a duly authorized agent and representative of the agency. This agency or representative **MUST** be authorized to negotiate on behalf of the agency.
- ☐ Service expansion includes the development of new or expansion of current Group Homes or other congregate care treatment facilities that are not presently recorded in TNKIDS. Non-payable placements which are present in TNKIDS are not linked to a provider's current contract and **may not** be considered a part of a provider's contracted capacity.
- ☐ Regional staff may request a provider's congregate treatment facility and /or Group Home) service expansion through CPPP by completing the Announcement of Funds (AOF) form. No expansion should be

speculative in nature since these requests must first be routed through CPPP and approved by the Commissioner of the Department. This protocol is in adherence with guidelines set forth through the State's Department of Finance and Administration.

II. PERSONNEL REQUIREMENTS

A. PERSONNEL POLICIES AND PRACTICES

1. The agency has written personnel policies that are formally adopted by the governing body, reviewed at intervals no greater than every two (2) years, and readily available to personnel.
2. Personnel policies specify the responsibilities of all employees, volunteers, and the agency.
3. Agency policies address personnel practices; confidentiality; working conditions; wages and benefits; insurance protections provided for personnel including unemployment, disability, medical care, liability for malpractice and use of agency premises, motor vehicles, and/or other equipment, as appropriate; and training and development opportunities for personnel.
4. The agency has a written job description for each agency position or group of like positions that clearly states qualifications and responsibilities.
5. The agency maintains a work schedule of personnel assigned to a service or department including names, dates, hours, and tasks, or implements another functionally equivalent mechanism accounting for assignments.
6. The agency complies with applicable laws and regulations governing fair employment practices and contractual relationships.

B. BACKGROUND CHECKS AND VERIFICATIONS

Tennessee Codes Annotated § 37-1-414, § 37-5-511, § 49-5-413, and § 71-03-507 require background investigations for all persons who have direct contact with children. Pursuant to those codes, the Department of Children's Services (DCS) Internal Affairs Division is tasked with the processing of fingerprints and it is responsible for reviewing and distributing the results of fingerprint-based background checks for the Department and associated contracted providers. Background investigations consist mainly of fingerprint verifications through the Tennessee Bureau of Investigation (TBI) and Federal Bureau of Investigation (FBI). The submission of fingerprints is done through the statewide sole source contractor. The contractor obtains and processes electronic copies of fingerprints gathered from sites across the state of Tennessee. The results from these fingerprint submissions are electronically submitted through the Tennessee Applicant Processing System (TAPS) to the Internal Affairs (IA) Division. Internal Affairs retrieves this data daily and informs the different DCS regions and/or contractors of results as they become available. This is the only acceptable method for fingerprint-based background investigations to be conducted for prospective resource parents (by DCS definition this includes foster, kinship, and adoptive parents), volunteers, and employees who are mandated to

have a fingerprint-based background investigation.

1. Provider agencies shall be responsible for all costs associated with obtaining, handling, and processing fingerprint samples submitted to the TBI and FBI for background checks to be done.
2. Provider personnel must meet all applicable state licensing and/or certification requirements for their agency and use of professional titles. A provider agency must obtain and maintain proof of licensure.
3. A provider agency routinely obtains and documents three references from unrelated persons for all personnel.
4. Provider agencies will have fingerprint-based background checks conducted on all prospective employees, resource parents, and volunteers having direct contact with children.
 - a. All governmental law enforcement agencies will obtain these free of charge as allowable through currently established protocols. The results of these checks will be submitted to the DCS Internal Affairs Division for review immediately upon receipt. An official letter of clearance or non-clearance will be issued by the IA Division. Agencies must maintain such letters in personnel files.
 - b. All other contracted agencies must obtain these checks through the IA Division. Information and instructions about fingerprinting procedures are available by checking the Tennessee Applicant Processing Services (TAPS) web site links found on the TBI home page at www.tbi.state.tn.us/.
5. All provider agencies are required to provide fingerprint samples for fingerprint-based background checks. Fingerprinting shall be conducted no later than at the time of employment on all new employees. When an employee is hired directly from DCS or another DCS contracted agency, a copy of that person's fingerprint results may be obtained from the prior employing agency or the DCS Internal Affairs Division. Prior results may be used and considered valid only if the employee had a period of unemployment between agencies of 30 days or less **and** the results are less than one year old. If prior results are used, both the date the employee left the previous employer and the hire date must be clearly documented. This provision also applies to any resource parent who was with DCS or another provider agency immediately prior to the current agency. This does not apply to any other required background checks; those must all be done. All resource parents will be fingerprinted during PATH training.
6. The United States Department of Justice has a national sex offender registry on-line at www.nsopr.gov/. After agreeing to the conditions of use, a

nationwide check may be run by name or checks may be run in individual states. At a minimum, sex offender registries associated with out-of-state addresses identified for the last ten (10) years must be checked. If all addresses in the last ten (10) years are within the State of Tennessee, the TBI list of convicted sex offenders can be accessed directly on the Internet at www.tbi.state.tn.us/. All employees, volunteers, and resource parents without a TBI Sex Offender registry check on file must be checked against this registry regardless of hire or approval date. Additionally, such documentation must be maintained in their files. Any individual appearing on any sex offender registry is inappropriate to employ for any children's services program managed by DCS or a provider agency. Form CS-0547, titled SEX OFFENDER REGISTRY VERIFICATION was developed for such documentation. Provider agencies must use and maintain in file either a CS-0547 or an agency document including the individual's name, SSN, agency, results, date verified, and the name of the person who verified the results.

7. DCS Policy 14.24 Child Protective Services Background Checks

<http://www.tennessee.gov/youth/dcsguide/policies/chap14/14.24%20Child%20Protective%20Services%20Background%20Checks.pdf>

Agencies must check with the DCS Child Protective Services Division to determine if any prospective employees, volunteers, or resource parents were ever investigated by this agency. This check includes searches of the Social Service Management System (SSMS) and the TNKids system in which information regarding child abuse and neglect issues is kept. To do this, the provider must fax a request on agency letterhead for a CPS background check to (615) 532-6495 with the following information:

- a. Full name of person
 - b. Social security number
 - c. Date of birth
 - d. Race.
8. In accordance with T.C.A. § 68-11-1006, T.C.A. § 37-5-511 (d)(1), and T.C.A. § 71-3-507 (e)(1)(A)(i)(d) all agencies are required to check all persons applying to work with children against the Tennessee Department of Health's vulnerable persons registry. Additionally, DCS requires this check to be done for all resource parents. The Tennessee Department of Health (DOH) is required to maintain a registry of persons who have abused or neglected vulnerable individuals or misappropriated their personal property. The physical address for the Elderly or Vulnerable Abuse Registry is Tennessee Department of Health,

Elderly or Vulnerable Abuse Registry, 1st Floor, Cordell Hull Building, 425 Fifth Avenue North, Nashville, TN 37247-1010. This registry is identified on the DOH Web site as "Abuse Registry" and may be checked free-of-charge at www2.state.tn.us/health/abuseregistry/index.html. Agencies must maintain documentation on file including the individual's name, SSN, agency, results, date verified, and the name of the person who verified the results.

9. According to T.C.A. § 37-5-511 (d)(1) and T.C.A. § 71-3-507 (e)(1)(A)(i)(d) prospective employees indicated on the department of health's vulnerable persons registry are disqualified from employment or from having access to any children in the care of the agency.
10. All potential employees and resource parents applying for positions that involve any contact with children shall be required to submit to criminal background **check** prior to employment. This information must be obtained from the Criminal Court, Municipal Court, and General Sessions Court from each jurisdiction where the applicant has been a resident during the last five (5) years. These criminal background checks are in addition to the requirement for TBI/FBI fingerprint check, CDP records checks, and the internet clearance checks currently required by DCS policy. The use of internet services such as Kroll or myCertifphi to obtain the required criminal background check is authorized, but it is the responsibility of the provider to ensure that the service they use can produce a check of the courts identified above. All cities and counties of residence for the past five (5) years must be checked. In the event someone lives outside of city limits, the city associated with the person's physical address is to be checked in addition to the county. If there is no city law enforcement (for example, in an unincorporated town) and the county handles all law enforcement duties, clearly document this as the reason that specific check is not on file.
11. No DCS employee or private provider's employee who has any contact with children shall have been convicted of a felony for any offense designated as a crime against a person, or have been the subject (i.e., perpetrator) in any substantiated or indicated case of child abuse or neglect. (Reference: T.C.A. § 37-5-511 and T.C.A. § 71-3-507.) An individual who has been convicted of any felony may be employed by DCS or a private provider agency in a position involving contact with children only if
 - a. the felony conviction occurred at least five (5) years prior to the employee's hiring; **and**
 - b. the employee has **not** been convicted of any other criminal offense since the felony conviction as demonstrated by city and county law enforcement record checks; **and**

- c. the DCS regional administrator or agency program director personally reviews the circumstances of the applicant. Additionally, the reviewer must personally document, with justification, that the employee could work productively and constructively with the type of children in their care.
12. An individual who has been convicted of any misdemeanor may be employed by DCS or a private provider agency in a position involving contact with children only if the DCS regional administrator or agency program director personally reviews the circumstances of the applicant. Additionally, the reviewer must personally document, with justification, that the employee could work productively and constructively with the type of children in their care. Employment will be terminated immediately, at the discretion of the regional administrator or agency program director, if any employee for whom the above criteria were satisfied is, or becomes, the subject of a criminal investigation or the subject in any substantiated or indicated case of child abuse or neglect during his/her employment. The regional administrator's decision shall be based upon the level of risk that the employee may or may not pose to the children and families with whom he/she would interact. This provision is not applicable to convictions for delinquent offenses prior to 18 years of age, unless the individual was tried and convicted as an adult. The State of Tennessee Department of Children's Services Administrative Policies and Procedures Policy 4.12 requires employees to report any arrest within 24 hours. This provision shall also apply to all provider agency employees and resource parents.
13. Prior to the receipt of results of fingerprint-based background checks new employees may begin work with children. Such work may begin only after all other required screenings and background check results have been received with no indication of any criminal history. To DCS, a criminal history for this specific purpose does not include misdemeanor traffic violations identified only in a driving record check. Employees must have been fingerprinted and employment must be conditional pending the results of the fingerprint-based background check. The new employee may have contact with children only when in the presence of employees who have been cleared to work. Clearance must be documented either by the results from fingerprint-based background checks or through the administrative approval procedures identified in 12 or 13 above. "In the presence of . . ." means **staff are never to be left alone with children**, including when a cleared employee takes any type of break. Fingerprint-based checks are separate from the other criminal background checks required prior to hiring a new employee.

C. PERSONNEL FILES

1. Provider agencies shall maintain a system of personnel records for all employees and those volunteers who have direct contact with children.
2. Each record will contain identifying information, a current job description, names of persons to contact in case of emergency, performance evaluations, and all documents pertaining to performance including disciplinary actions.

Providers shall develop and retain clear policies/tools surrounding annual performance evaluation and disciplinary action guidelines. Such evaluation policies/tools shall include, **at a minimum**, an annual evaluation of performance for each level of staff within the agency. Policy shall clearly indicate actions that will be taken by the agency for failure to receive a satisfactory job performance evaluation during any evaluation period.

3. Prior to the initiation of employment, the approval of volunteers, or the approval of resource parents, agencies must obtain, verify, and maintain in each employee **and** resource parent file the items listed below. All background (except fingerprints) and registry checks must be run for all known aliases which are not obvious variations of the person's name. Citations following some particular items are located in this chapter and have specific details relevant to the associated item.
 - a. An application
 - b. Three (3) letters of reference (see B.3)
 - c. Verification of education including diploma(s) and/or transcript(s), as required for the particular position
 - d. Documentation of prior experience
 - e. Health certificate of screening conducted by a licensed medical provider
 - f. Agreed upon terms of employment, including signed documents or agreement to agency policies on confidentiality and child abuse reporting
 - g. A valid motor vehicle driver's license from the state of residence (New Tennessee residents are required to obtain a Tennessee driver's license within 30 days.)
 - h. Driving record background check
 - i. Proof of vehicular and medical liability insurance for anyone who will be transporting children in DCS custody
 - j. Court record checks (see B.10)
 - k. Sex offender registry verification (see B.6)
 - l. Elderly or vulnerable abuse registry verification (see B.8.–B.9)

- m. Results from DCS Child Protective Services' search (see B.7)
 - n. Fingerprint-based background check results are not required prior to hire but must be filed immediately upon receipt. (See the introductory paragraph to section B., B.4. and B.5.)
4. All volunteers who have direct contact with youth and all persons over the age of 18 (who are not resource parents) residing in a resource home must have the same screening, background checks, and fingerprint-based background checks completed and on file as employees. Additional specific information is in section B, C.2 and C.3.
 5. When all provisions of B.13, above, are met, new employees are eligible to begin work with children as described. This is prior to results of the fingerprint-based background checks.
 6. Additional information added to the employee files throughout the period of employment includes:
 - a. Documentation of training;
 - b. Updated health cards or reports of annual physicals, when required by law;
 - c. Renewed motor vehicle driver's license (this also applies to resource parents);
 - d. Renewed vehicle insurance showing vehicular and medical liability coverage (this also applies to resource parents);
 - e. Awards and recognition;
 - f. Termination summaries; and,
 - g. Additional written documentation regarding personnel when agency policies and procedures require its inclusion.

D. STAFF QUALIFICATIONS

1. The agency retains personnel qualified to carry out its program of services.
2. Specific criteria for hiring, training, and promoting shall apply to all family services workers and supervisors with direct responsibility for the cases of foster children.
3. **Program Director** The program director (or other position title having responsibilities listed below) is qualified by education, training, experience, and management skills to ensure effective utilization of the agency's personnel and financial resources and coordination of the agency's program of services with other community services. The program director's responsibilities include but

are not limited to agency planning; budget preparation; recruitment, selection, and hiring of employees; training; interpretation of the agency's program to the community; and implementation of the agency's policies and procedures. In small programs, the program director may also be responsible for providing treatment or supervising treatment staff. In this situation (or any other in which a staff member fulfills the roles/responsibilities of more than one position), the program director must meet all the qualifying requirements for the staff member who typically has that job responsibility.

Qualifications for Program Director

The **program director** has at least a bachelor's degree from an accredited program of social work education or an advanced degree from an accredited academic program in another field of human service with at least two years of progressively responsible supervisory and management experience in direct services for individuals, families, and children or in another field directly related to the service being provided.

4. **Clinical Services Director** The clinical services director (or other position title having responsibilities listed below) is licensed to supervise clinical or medical programs and meets all requirements to provide supervision and services under license requirements for this particular profession.
5. **Clinical Service Provider (therapist)** (or other position title having responsibilities listed below) is an appropriately licensed or certified professional who may work directly with children and families or may serve as treatment and program consultant to the agency's casework supervisor staff. This individual may be on staff with the agency or may be a contracted service provider. Staff members providing therapy services must be eligible to do so under state licensing and supervision requirements.

Qualifications for Clinical Service Provider

The **clinical service provider** must be appropriately licensed or certified and be a medical doctor or have a master's degree, Ed.D., Ed.S., or Ph.D. in the behavioral sciences. Five years of pertinent experience is desired. The clinical service provider's area of concentration or experience should be appropriate to the issues of consultation. An individual with a master's degree who is on a licensure track and under the supervision of a licensed practitioner is acceptable as a clinical service provider. All required documentation for licensure track and supervision should be included in the personnel file of the clinical service provider.

6. **Case Manager Supervisor** (or other position title having responsibilities listed below) may be a full-time employee of the agency or a part-time contracted

employee. The case manager supervisor's responsibilities include oversight/supervision of case management staff, coordination of training for staff, review of family services worker work activities and products, and approval of foster home/adoptive home studies.

Qualifications for Case Manager Supervisor

The **case manager supervisor** with supervisory responsibility for family services workers (may be called case workers, social workers, family workers, etc.) shall have a minimum of a master's degree from an accredited college in social work or related behavioral field with a child or family focus and at least three years experience as a case worker in child welfare.

7. **Case Manager** (also referred to as case worker, social worker, family worker, etc., or other position title having responsibilities listed below) is generally a full-time employee of the agency working on site; however, some agencies may contract for part-time casework services. The family services worker may be the "front line" worker with children in some facilities. Family services worker responsibilities include participation in development of treatment plans; implementation of treatment plans (if applicable) for children and/or families; maintenance of casework documentation and progress notes; serving as liaison between DCS and schools; therapeutic support to children regarding educational goals, anger control, grief issues, separation issues, and other personal/family issues; crisis intervention; transportation of children; developing foster/adoptive homes studies; and facilitation of group process and structured treatment activities.

Qualifications for Case Manager

The **case manager** must have a minimum of a bachelor's degree from an accredited college with a major in social work or a related field and one (1) year of pertinent experience in the human services field with children or in a residential treatment setting. Volunteer experience and practicum and intern experiences in programs/facilities that work with children and families may be counted as pertinent work experience. A master's degree in the social sciences may be substituted for the one year of work experience (does not apply to family services workers holding their positions as of October 1, 2001).

8. **Child Care Worker Supervisor** (or other position title having responsibilities listed below) is the direct supervisor of the direct care workers. Responsibilities of the child care worker supervisor include providing a role model for children; supervision of direct care staff and children; participation in and supervision of

recreational activities; assisting in preparation of meals and the supervision of children during meals; encouraging/assisting children in the practice of proper hygiene; transportation of children; reporting significant events that occur during the shift; and assistance in crisis intervention.

Qualifications for Child Care Worker Supervisor

The **child care worker supervisor** must have an associate's degree with emphasis in working with children. One (1) year of experience working in a children's services program is required with experience in a residential setting. Two additional years working in a residential setting with children may count for the associate's degree.

9. **Child Care Worker** (or other position title having responsibilities listed below) provides the direct supervision for children. Responsibilities of the child care worker include providing a role model for children; supervision of children in completing household chores; participation in and supervision of recreational activities; assisting in the preparation of meals and the supervision of children during meals; encouraging/assisting children in the practice of proper hygiene; transportation of children; reporting significant events that occur during a shift; and assistance in crisis intervention.

Qualifications for Child Care Worker

The **child care worker** must have a minimum of a high school diploma or a GED. One (1) year of experience working in a children's services program is preferred. Volunteer experience and practicum and intern experience in programs/facilities that work with dysfunctional children and families may be counted as pertinent experience.

E. STAFF TRAINING Pre/in-service Training for Direct Care Staff, Case Managers, and Case Manager Supervisors (For Resource Homes, see Section II, Foster Care/Resource Homes)

Personnel development is an ongoing, integral, and identifiable part of the agency's program of services, and the agency has specific guidelines as to the time commitment expected of personnel in various positions. An agency which contracts with DCS ensures that qualified personnel meet or exceed the requirements for pre-service and in-service with respect to agency objectives, policies, services, community resources, DCS policies, and best practice standards.

1. PRE-SERVICE TRAINING HOURS

- a. **Direct Care Staff.** Thirty (30) hours of pre-service training.
- b. **Case Manager.** Case managers will complete or will have completed (see Substitution of Required Pre-service and In-service Training below) the following pre-service training before assuming full responsibility for a case, except as part of a training caseload: **eighty (80) hours of pre-service instructional training and eighty (80) hours of pre-service on-the-job or supervised field training.** On-the-job (OJT) or supervised field training may include but is not limited to shadowing a trained employee to visits, court, foster care review meetings, CFTMs, and residential activities. Every activity shall be documented by outlining what was completed and who was seen; dates and hours of OJT credit are to be recorded in a notebook, or similar format, to become part of the case manager's personnel file. The agency employee supervising the OJT shall verify the training documented by the case manager.
- c. **Case Manager Supervisor.** Forty (40) hours supervisor pre-service training. All pre-service training must be completed and documented within the first ninety (90) days in the position and prior to assuming case manager supervisor duties.

2. **PRE-SERVICE TRAINING TOPICS.** Training for direct care staff, case managers, and case manager supervisors should include skills and information which enhance staff ability to carry out the agency's programs; work cooperatively and effectively with other personnel who fulfill different tasks or responsibilities; and demonstrate an awareness, sensitivity, and appreciation of the cultures and perspectives of the children and families served by the agency. Pre-service and in-service training requirements for resource homes are located in this manual in Section Two -Resource Homes.

Specific training topics for indicated personnel include but are not limited to the following:

- a. **Non-Direct Care Staff.** The agency has discretion regarding training requirements and topics.
- b. **Direct Care Staff, Case Manager, and Case Manager Supervisor.**
 - 1. Agency mission statement, history, and policies
 - 2. Health and safety
 - First aid
 - CPR (agency must ensure that someone must be immediately available who has been trained in CPR when supervising youth)

- De-escalation
 - Restraint (where appropriate). All staff involved in and monitoring restraints must be CPR-certified and fully trained and certified in nationally recognized physical restraint methods. Please see DCS Policy 27.3 on restraint.
 - Medication administration (training should be provided to anyone, including staff and resource parents, who will be administering or supervising the administering of medication)
 - Incident reporting
 - Recognition of substance abuse
 - Child abuse prevention/reporting
 - Suicide prevention
 - HIPAA/confidentiality
3. Policies and procedures
- Sexual harassment prevention
 - Cultural awareness
 - DCS Policy where applicable
 - Provider Policy Manual
- c. **Case Manager and Case Manager Supervisor.** The agency is to ensure new case managers and case manager supervisors are competent in the professional knowledge, skills, and attitude surrounding services to children and families. Upon hire, the agency will provide or provide access to competency-based training. Recommended/suggested topics may vary based on agency-specific population(s).
1. Professional knowledge, skills and aptitudes
 2. Child and Family Team Meetings
 3. Functional Assessments
 4. Parent Engagement
- d. **Case Manager Supervisors.** Supervisory skills training.

3. IN-SERVICE TRAINING HOURS Direct care staff, case managers, and case manager supervisor development is an ongoing, integral, and identifiable part of the agency's program of services. Agencies should provide in-service training and continuing education opportunities to ensure that its staff members have the specialized skills and

knowledge necessary to provide quality services. The in-service training curriculum should include competency-based modules to ensure that staff continues to improve their knowledge of family, children, and the community. In-service training requirements begin after the first year of employment following pre-service and are tracked and documented by hire date.

- a. **Direct Care Staff.** Twenty-four (24) hours annually.
- b. **Case Managers.** Forty (40) hours annually.
- c. **Case Manager Supervisors.** Twenty-four (24) hours annually.

4. IN-SERVICE TRAINING TOPICS/METHODS

- ☐ mandatory topics repeated for continued certification
- ☐ quality improvement activities
- ☐ implementation of new policies and procedures
- ☐ specialized training topics
- ☐ guest speakers
- ☐ conference trainings
- ☐ new initiatives from the Department of Children's Services
- ☐ development of new skill areas
- ☐ specialized reading materials
- ☐ specialized training as the needs of the clients change

5. SUBSTITUTION OF REQUIRED PRE-SERVICE AND IN-SERVICE TRAINING.

- a. Four (4) training hours per each semester hour of college credit completed within the current year in an applicable social science area may be substituted for annual training.
- b. A new employee who is hired within one (1) year after having left employment with another private provider children's services agency or the Department of Children's Services may be credited with the training hours received from the prior employment. Such hours may count toward the employee's current training requirements upon documentation of the previous training.
- c. An employee who has resigned in good standing from the agency's program and is rehired within one (1) year of the resignation is not required to repeat the pre-service training and in-service training if they were previously completed; however, the annual ongoing in-service training requirement must be fulfilled beginning with the date of rehire.

6. TRAINING PLAN AND DOCUMENTATION OF TRAINING HOURS

- a. On an annual basis, each private provider is required to submit, to DCS, a copy of the agency's projected staff development plan and training calendar which includes pre-service and in-service training topics and content. The plan will be reviewed, approved, and monitored by the Department of Children's Services Professional Development Division. Plans and calendar are due on or before April 30 for the upcoming contract year. Any changes to the plan or calendar will be submitted to the Department of Children's Services as an addendum within 30 days of the changes being instituted by the agency.

Agencies will receive a written notification of review and approval.

Pursuant to the Brian A. Settlement Agreement, all new providers and sub-contractors must have approval from DCS on all training plans and schedules prior to the approval of any contract.

Submit plans and schedules to the following address:

Tennessee Department of Children's Services
Professional Development and Training Division
Curriculum Coordinator
Menzler #3
1276 Foster Avenue, Nashville, Tennessee 37243

- b. The agency *documents* the participation of personnel in appropriate training. Any exemptions granted are based upon procedures which assess the demonstrated competency in tasks to be assigned. Agencies will provide proof by individual that training requirements are being fulfilled. Review of those records will occur during monitoring. Date of training, number of training hours, and signatures of participants obtained at the time of training will suffice as proof of training.

F. ACCOUNTABILITY AND REVIEW

1. The agency provides for a system of supervision and evaluation or other procedures for holding personnel accountable for the performance of assigned duties and responsibilities.
2. Frequency of individual or group supervision is arranged according to the level of skills of the provider and supervisor, the complexity and size of the workload, and the newness of the assignment.
3. At least once a year, personnel performance reviews are conducted jointly between

- each employee and the management or direct-service volunteer with ongoing responsibility and the person to whom he/she is accountable for his/her performance.
4. Performance reviews include an assessment of job performance in relation to the quality and quantity of work defined in the job description and to the objectives established in the most recent evaluation; clearly stated objectives for future performance; and recommendations for further training and skill-building, if applicable.
 5. When the agency employs, contracts for, or otherwise utilizes the services of a professional on a per interview, hourly, or other part-time basis, it holds those workers accountable in the same way it does its other personnel by requiring appropriate recording, participation in conferences or review processes as needed, and regular reporting to a supervisor or other senior personnel.
 6. Staff will not be permitted to take a child home on an overnight basis under any conditions or for any other reason(s) including working in staff's home(s). On very special occasions such as holidays, staff members may take a group of no less than two (2) children home for holiday-related activities. On such occasions a male and female adult must be present and prior written approval at least one week in advance must be granted by the DCS family services worker.
 7. Compliance with any/all other prohibitions as specified in the provider's contract must be maintained.
 8. **NOTE: The provider agency must not encourage nor in any way suggest to parents/guardians of a non-custodial child that the child should be put in custody in order to receive services.** If the agency is approached by the parent/guardian and the agency does not serve non-DCS children, the provider agency should refer the parent/guardian to the BHO or to the DCS Regional Well-Being Unit. The provider agency must not suggest custody by indicating the agency only serves custody children and not providing the parent/guardian with additional information. The department is better positioned through the Well-Being Units to discuss with parents/guardians options for services short of the state assuming custody.

III. GENERAL PROGRAM REQUIREMENTS

NOTE: All requests for waivers to policy must be submitted to Child Placement and Private Providers for review and approval/disapproval.

A. BRIAN A. SETTLEMENT AGREEMENT

Provider agencies shall adhere to the applicable mandates as set forth in the Brian A. Settlement Agreement: www.state.tn.us/youth/pdf/dfs/settlement.pdf.

B. CLIENTS RIGHTS, SEARCH PROCEDURES, ACCESS TO LEGAL COUNSEL

DCS Policy 24.13 Access to Legal Counsel for Youth in DCS Group Homes (for information)

<http://www.tennessee.gov/youth/dcsguide/policies/chap24/24.13%20Access%20to%20Legal%20Counsel%20for%20Youth%20in%20DCS%20Group%20Homes..pdf>

1. The agency protects client rights in all phases of the agency-client relationship from initiation of service through aftercare.
2. A child or youth shall not be denied admission to a program and/or services due to an encountered language barrier.
3. The agency develops and implements policies and/or procedures that afford special protections to its clients.
4. The agency informs clients of the rights and responsibilities of client and agency.
5. Summary information about client rights is made available to all clients through a brochure or other written material that is available or posted in the agency's reception area or that is handed to clients during their initial contact with the agency.
6. Information about client rights is made available in a language that the client can understand, in sign language or in verbal or written form as may be required by a visually or hearing impaired client, or to the client's parents or legal guardian as well as to the client if the client is a minor or is mentally disabled. No client shall be denied admission to a program and/or services because of an encountered language barrier.
7. The agency takes a protective role with regard to the release of information about its clients.
8. The outgoing and incoming mail of clients in any form of out-of-home care is not

censored except that mail suspected of containing unauthorized, injurious, or illegal material or substances is opened by the addressee in the presence of designated personnel.

9. A child or youth placed out of his or her home has the right to visit the family in the family home, receive visits, and have telephone conversations with family members, when not contraindicated by the CFTM or permanency plan; have personal property and a place for safe storage; be free from exploitation in employment-related training or gainful employment; and express opinions on issues concerning his or her care or treatment.
10. A child or youth placed out of his or her own home has the right to receive care in a manner that recognizes variations in cultural values and traditions including, wherever possible, being placed with a family of the same or similar background and be free from coercion with regard to religious decisions.
11. The agency has a process to assure that, whenever practicable, the wishes of the parents with regard to a child's religious participation are ascertained and followed.
12. When the agency limits in any way the right of a client to have private telephone conversations with family members or others, the restriction is based on contraindications in the permanency plan or a CFTM, documented in the client's record, approved in advance and reviewed monthly by the home county family services worker, and based on documented short-term safety concerns.
13. The agency fulfills its responsibility for protection of the client and the community when the client may be endangered and/or may be harmful to others by written policies regarding disclosure of such client information to administration, parents, legal guardians, or community authorities and administrative review of case records to determine that appropriate disclosure takes place.
14. Agency policies prohibit the requirement or encouragement of public statements that express gratitude to the agency or using identifiable photographs or videotapes for public relations purposes without the consent of the client and, in the case of a client who is a minor, both the client and the parent or guardian of the minor client.
15. **Uniforms and jumpsuit policy.** The vast majority of children in DCS care enter custody not through any fault of their own but through the actions or inactions of adults in their lives. Therefore, DCS strongly urges child care agencies, whenever possible, to afford children the freedom to dress in ways that preserve their

dignity, their freedom of expression, and their cultural identity. At the very least, agencies are to refrain from using uniforms, outfits, or identifying visual markers according to children's disabilities, diagnoses, or referral behaviors. To do so classifies and stereotypes children in ways that add to the stigma or shame associated with being in the custody of the state. Generally, wearing one's own clothing should not be held out as a reward but as a basic right. Additionally, any facility policy which requires uniform or identifying clothing when a child is in a community setting; i.e., community schools **must be eliminated immediately**.

DCS recognizes the need for agencies to utilize dress codes in order to maintain standards of hygiene and decency or to maintain accountability to the youth at certain times. DCS challenges agencies to involve youth as much as possible in decisions about reasonable limits of clothing or dress codes. Some private agencies have used jumpsuits similar to those used in correctional facilities to prevent runaways. It should be noted that correctional jumpsuits are only appropriate for correctional settings such as detention centers. Also, the literature on runaway behaviors suggests that children run more from controlling, distant environments than from engaging ones, so how facilities interact with children is more important than the types of control measures they employ to prevent runaways.

16. **Search Policy**

The goal of DCS is to maintain the dignity and privacy of every child in custodial care. There are those occasions, however, when the searches may be required to ensure the safety of the child and others. The agency shall make every effort to preserve and maintain the rights and dignity of each child to be treated respectfully when searches are necessary. The agency must establish a search policy.

The policy shall include the means to

- a. maintain appropriate search methods that are respectful of client's rights and maintains the dignity of children/youth;
- b. establish procedures to ensure searches of children/youth and their personal property are conducted by identified, properly trained staff;
- c. select trained same-gender staff to conduct searches of adolescent youth whenever possible;
- d. have at least two (2) staff members present and able to take part in every search;
- e. implement an agency process for the Prior Notification of the child, a parent or guardian of those instances when searches might be conducted during a child's stay in the program;

- f. perform an administrative review of the process for documentation, notification, monitoring of the policy as part of an ongoing quality review; and
- g. document the reasonable cause and assessed risk of harm to self or others which triggers any search in a narrative format.

17. **Types and Guidelines for Searches**

- a. **Non-Invasive Searches:** Non-invasive searches range from a visual inspection of appearance, which is expected at all service levels, to a child-driven search, such as the turning out of pockets and a self-pat-down with staff watching, or in some cases the use of standard scanning equipment or wands designed to capture metal or dense objects. Most programs Level II and below need only conduct non-invasive searches. Level II programs with special populations, such as A and D or SO programs, may require a more invasive search to identify and prevent certain types of contraband.
- b. **Invasive Searches:** Invasive searches are those in which there is either staff/child physical contact, such as a pat down search, or a clothing search which would involve the removal of a child's clothing. Invasive searches are always conducted by the same gender staff as the child being searched. Pat-down searching does not involve the touching of private areas (those which would be covered by a swimsuit).
- c. **Clothing Removal:** Only allowed in those programs in which safety is a regular concern. This includes Level IV programs which need to take certain precautions for safety, particularly for those children who are at risk of harming themselves or others. Searches should be limited to admissions and readmissions following unsupervised outings or home passes or suspicious activity which would suggest hidden objects or weapons. Procedures for this search are described elsewhere, but the rule of thumb is that children are not monitored while disrobing.
- d. **Search Criteria A:** All programs are allowed this level of search at any point (Intake/Admission, return from pass, suspicious activity, staff discretion, etc.)
- e. **Search Criteria B:** Criteria for searches at B level involve circumstances in which a child is returning from an unsupervised home visit, from a community-based school, or other times in which the child has been out of the range of normal staff or DCS supervision. Trips to court with a DCS family services worker and uncomplicated outings or recreation center visits are examples of activities that do not meet these search criteria.

- f. **Search Criteria C:** Some programs must search children even when they have left the facility in the care of a responsible adult (family services worker or agency staff) such as a court or doctor's visit, because the child has had contact with other family members or other children that are not DCS charges or participants in the program in which as child is placed. This triggers the possibility of pat down searches for those levels of care where such a search is allowed.
- g. **Search Criteria D:** Searches may be allowed if a child engages in suspicious activity regarding objects or persons which would indicate possible concealed contraband. Specific to the levels of care marked, and only upon objectively formed suspicion of a safety issue.
- h. **Search Criteria E:** Clothing searches may be performed by Alcohol and Drug programs with strict adherence to the procedures for clothing searches when warranted by unsupervised contact with persons outside the treatment setting.

C. GRIEVANCE PROCEDURES

Agencies may use the following DCS policies as a guide, for information:

DCS 24.10 Title VI Program and Complaint Process

<http://www.tennessee.gov/youth/dcsguide/policies/chap24/24.10TitleVIProgramandComplaintProcess.pdf>

DCS Policy 24.11 Grievance Procedures for Youth in DCS Group Homes

<http://www.tennessee.gov/youth/dcsguide/policies/chap24/24.11%20Grievance%20Procedures%20For%20Youth%20in%20DCS%20Group%20Homes.pdf>

1. The agency has written client grievance policy and procedures that provide clients with a means of expressing and resolving a complaint or appeal.
2. The agency provides basic information to its families and children about the means to lodge complaints or appeals when decisions concerning them or services provided them are considered unsatisfactory.
3. At the time a complaint occurs, the client or parent or legal guardian, as appropriate, is provided with a copy of the agency's written grievance policy and procedure.
4. The agency acts on any complaints in accord with its stated procedures and time lines and documents that it does so.

5. The client is informed of the resolution of any complaint and a copy of the notification is maintained.
6. The agency has a review and reassessment process that includes governing body review of the resolution of client grievances, which is carried out in a manner that protects client confidentiality.
7. Residential programs will have a locked grievance box on site for any youth, staff, or family complaints. The agency will have an administrative staff to review and respond to complaints.

D. SERVICES TO ALL CHILDREN IN CUSTODY

The services are provided to children in order to meet their permanency needs. They are provided through a team approach; the roles, responsibility, and leadership of the team are clearly defined; and there is a system of task allocation among team members for implementation of the service plan.

1. The service plan includes
 - a. provision for meeting the child's normal dependency and developmental needs (child care, education, health, religion, and community activities);
 - b. specialized services as required to meet the child's individual needs that are integrated with the child's daily living experience and focus on achieving permanency;
 - c. nutritious meals and snacks, companionship, and an atmosphere that is pleasant and conveys dignity and respect for the child;
 - d. support and assistance as needed for positive participation in group living and community activities, provided individually or through daily process groups;
 - e. maintenance of an orderly daily life in which the child can develop and enhance positive personal and interpersonal skills and behaviors;
 - f. provision of personal needs such as clothing and an individual allowance (when required);
 - g. the opportunity to participate in recreational activities and receive an educational program in the community;
 - h. opportunities for spiritual development respecting the child's background, beliefs, and culture;
 - i. opportunities to participate in family and neighborhood activities that are consistent with a child's ethnic and racial heritage;
 - j. engagement of the child's parents in the placement and planning process;

- k. recruitment or development of family and support resources; and
 - l. retention and expansion of the maximum feasible family involvement in decision making and maintenance of contact between family and child (unless clearly contraindicated by child and family team).
2. Services are provided throughout care to help the child to
- a. understand and participate, where appropriate, in planning for services and setting goals for both the child and his or her parents and any changes in the plan as they occur;
 - b. resolve conflicts and achieve understanding relating to separation from family or other significant adults, feelings toward them, and prospects for returning home or living in another family;
 - c. continue the relationship with siblings and extended family through visits and shared activities;
 - d. understand the role of the child care professionals and other personnel and consultants who may be working with him or her;
 - e. understand and accept the placement environment and the relationships available there;
 - f. become familiar with community resources such as banks, employment and other government offices, recreational and educational organizations; and
 - g. prepare for discharge and reintegration into the family or other most appropriate setting.

3. Health services include

- a. coordination of services meeting **Early Periodic Screening Diagnostic Treatment (EPSDT)**, behavioral/medical guidelines,

DCS Policy 20.7 TENNderCare Early Periodic Screening Diagnostic Treatment Standards

<http://www.tennessee.gov/youth/dcsguide/policies/chap20/20.7TennnderCareEarlyPeriodicScreeningDiagnosisandTrea.pdf>

DCS Policy 20.12 Dental Services;

<http://www.tennessee.gov/youth/dcsguide/policies/chap20/20.12DentalServices.pdf>

- b. a written summary of the youth and the family's known medical history including immunizations, operations, and childhood illnesses

DCS Policy 20.25 Health Information and Access;

<http://www.tennessee.gov/youth/dcsguide/policies/chap20/20.25%20Health%20Information%20Records%20and%20Access.pdf>

- c. documentation that the youth has received age-appropriate instruction regarding teen pregnancy prevention, AIDS prevention, and general information about the prevention and treatment of disease
- d. a copy of documentation of receipt of all needed health services sent to the Regional Services and Appeals Tracking (SAT) Coordinator;
- e. appropriate feminine hygiene items provided to female youth and made readily available, including sanitary napkins and tampons; counseling by staff for minor females regarding risks of toxic shock syndrome (must be documented in child's record) involved in the use of tampons; a choice between tampons and napkins; and
- f. direct provision or referral for needed services;
- g. providing coordination of care when an acute hospitalization occurs, including follow through on medications, clothing, and discharge planning;
- h. medication administration in accordance with the DCS Policy 20.15 and
- i. provide information to pregnant youth under the age of 18 using

DCS Policy 20.9 Court Advocate Program

<http://www.tennessee.gov/youth/dcsguide/policies/chap20/20.9CourtAdvocateProgram.pdf>

which provides a court-appointed advocate to represent the youth in court.

- 4. The agency arranges and maintains stable placements for children by
 - a. ensuring early intervention for behavioral problems;
 - b. ensuring ongoing support for the placement and the child to address any problem areas;
 - c. providing respite to placements;
 - d. providing 24-hour crisis or support services to families; and
 - e. notification of abuse or allegations of abuse should be reported immediately to CPS and FSW, and an Incident Report should be completed in accordance with TCA 37-1-403.
- 5. The agency is responsible for providing independent living training and skills building if serving youth 14 and older.

E. Movement Reporting and Compliance

The agency shall have in place an administrative mechanism to review the following:

- 1. **Movement**

Provider compiles information on each youth who moves from one location to another location of any type during the month.

A move is any change in placement location (such as a foster home, cottage, or residential or other placement) including temporary breaks in service. A change in location includes moves from foster home to foster home or from cottage to cottage as well as a change in program. There are two types of moves: *planned* and *unplanned*.

a. **Planned Move**

A planned move is a move that occurs as a result of a child and family team meeting (CFTM) prior to the move, with all involved adults and age-appropriate children. Process to be followed in a planned move:

1. As a result of the CFTM, consensus regarding the move is achieved in the best interest of the child.
2. A permanency CFTM form or other staffing form is signed by all, documenting the meeting.

b. **Unplanned Move**

Unplanned moves are non-compliant with best practices, therefore are subject to incur penalties unless there is clear and compelling evidence the move is due to an imminent child safety issue. The provider must report any unplanned move within 24 hours of the move to the Regional Placement Services Division, as detailed in item f. of this policy section. Unplanned moves require a CFTM within 72 hours of the next business day subsequent to the movement.

NOTE: Psychiatric and medical hospitalizations ARE NOT considered a move.

2. **Temporary Breaks**

Temporary breaks are interruptions or temporary breaks in placements. These include the following:

- a. Runaway and the bed is being held;
- b. Medical or psychiatric hospital and the bed is being held; See PACC Psychiatric Acute Care Coordination
- c. Child is in a residential program and is authorized to have transition to a foster home prior to the move to the foster home.
- d. **Respite** A respite placement is a brief stay in a home, foster home, or cottage with the expectation that the child will be returning to the original placement. Respite is not to exceed 72 hours without having a CFTM. Any respite which exceeds 72 hours will count as a move unless

otherwise stipulated by the CFTM.

NOTE: Respite cannot be used to circumvent or avoid reporting a move or disruption.

3. **Process for Reporting a Move**

Any move must be preceded by a CFTM unless there is an imminent child safety issue. In these instances, the Family Services Worker (FSW) and regional placement services staff must be notified within twenty-four (24) hours of the move and a request made to convene a CFTM. All moves must be reported to the Regional Resource Services Division no later than 24 hours after a move has occurred.

a. **Movement Notification**

Providers must notify the FSW whenever a child moves from one location to another or has any type of temporary break in placement. Notification to the FSW must be in accordance with Placement Change Notifications and Provider Procedures section.

b. **Placement Change Notifications and Vendor Procedures**

A new feature in TNKIDS Financials enables agencies to notify regional offices when children move from one location to another. This feature is designed to enhance the regional offices' ability to keep TNKIDS up-to-date and to prevent authorization and invoicing problems.

Instructions can be found on the Provider Web site at www.state.tn.us/youth/providers/index.htm. Click on *Financials Placement Change Notifications CBT for Provider's Slideshow*.

F. **Placement Exception Requests**

DCS Policy 16.46 Child/Youth Referral and Placements Attachment

<http://www.tennessee.gov/youth/dcsguide/policies/chap16/16.46%20Child%20Youth%20Referral%20and%20Placement.pdf>

DCS staff and administration are responsible for any PER required for the initial placement of a child/youth with an agency, but the agency should keep a signed copy of the form in the child's file. For any *subsequent move* within the program that deviates from acceptable moves, the *provider* must complete the PER and provide detailed justification for the move and setting selected. Once the agency completes the PER form, the form is then sent to the regional contact for approval***. The placement CANNOT be made prior to the Regional Administrator's approval. In emergency situations, RA verbal approval is acceptable, but the provider should seek written confirmation from DCS that verbal approval has been granted.

The agency should keep a signed copy of the PER form in the child's file.

***If a region is not responsive to the request for PER approval or for a signed copy of the PER, then the CPPP Regional Coordinator should be contacted immediately.

A Placement Exception Request (PER) must be sought in the following situations:

1. Placement is not within region and beyond the 75-mile limit;
2. More than two (2) children in a foster home under age two (2). This applies to both foster children and the resource family's natural and/or adoptive children. A PER is required for each custodial D/N or unruly child/youth in the home;
3. A total of FIVE (5) or more children including the resource family's natural or adopted children (A PER is required for each custodial D/N or unruly child/youth in the home.);
4. Siblings not placed together;
5. Child under age six (6) placed in a group care non-foster home family setting;
6. Child placed in a residential treatment center or group care setting with capacity in excess of eight children;
7. More than two therapeutic foster children in a foster home;
8. Shelter placement in excess of 30 days; and/or
9. Multiple placements – emergency, emergency shelters, or temporary facility placements are limited to thirty (30) days only, within a 12-month period. An exception to the multiple placement limit within any 12-month period may occur for an individual placement episode for a maximum of five days and under certain conditions, and with assurances from the RA, up to a maximum of fifteen (15) days.

G. Detention, Runaways, Hospitalizations

1. **Detention:** DCS shall reimburse providers for no more than 24 hours per child, per provider, per year for children placed in detention. Detention is not to be used as a method to disrupt a child out of a program. Any changes in placement must be as a result of a CFTM.

2. **Runaways DCS Policy 31.2 Responsibilities Regarding Runaways, Absconders and Escapees**

<http://www.tennessee.gov/youth/dcsguide/policies/chap31/31.2ResponsibilitiesRegardingRunawaysandEscapees.pdf>

DCS shall only reimburse for up to three (3) days per year, per child, per provider for children on runaway. Providers are not obligated to hold the bed open past three days; however, the child could be referred back to the

provider upon return from runaway. This should be processed as a new referral. Upon the child's return to care, a debriefing meeting must occur within 24 hours and will include, but is not limited to, the DCS FSW, the provider, the child, and all appropriate family members. The DCS FSW may participate by phone. At the debriefing meeting, a safety plan must be developed to reduce the likelihood of the child eloping prior to the CFTM. The CFTM meeting will be scheduled within seven (7) days of the child's return to care and a formal Safety Plan created to help prevent future runaways. The Safety Plan would include, but would not be limited to, mental health treatment, reunification/family counseling, medication management, specific extracurricular activities, etc. In addition, specific time and energy will be focused on working with the child to better understand the precursory issues that led to the child's elopement.

The CFTM is an essential part of this plan and this is the forum in which all involved parties have an opportunity to assess both the long- and short-term needs of a specific child through close observation and discussion of the child's behaviors and elopement patterns. This type of hands-on information may not be available through traditional testing or assessment instruments. As children are, in most cases, either running away from something or running to something, the department and private providers must look to systemic issues rather than solely focusing on the runaway behavior.

3. Hospitalization

The provider may be reimbursed for up to seven (7) days at the discretion of the region and with approval from the regional administrator or his/her designee. After seven days and up to twenty-one (21) days, the provider may be reimbursed with written approval from the regional administrator or his/her designee. An agency should not be reimbursed past 21 days; however, in the event that an agency and region agree that the agency should be reimbursed past this time, the Division of Child Placement and Private Providers must be notified and approval sought from the DCS deputy commissioner of protection and prevention.

H. Permanency/Successful Program Completion

Identifying information on youth leaving program to permanency placement, with discharge placement and type:

1. Successful non-continuum program completion/discharge: Youth left the contract successfully completing the program treatment plan.
2. Successful continuum completion/discharge: Youth left the program to the

permanency goal placement as outlined in the permanency plan (adoption, reunification, or kinship care).

3. Unsuccessful non-continuum program completion: Youth left the program without successfully completing the program treatment plan. Youth ran away and did not return; youth went to a hospital or detention center and did not return to the contract agency. This also includes youth who went to other programs/contracts without successfully completing this program/contract due to disruption.
4. Unsuccessful continuum program completion: Youth left the program without achieving permanency as outlined in the permanency plan. Youth ran away and did not return; youth went to a hospital or detention center and did not return to the contract agency. This also includes youth who went to other programs/contracts without successfully completing this program/contract due to disruption. Planned Permanent Living Arrangement is considered to be an unsuccessful continuum program completion.
5. Contract agencies will provide the following information on youth in care:
 - a. Length of stay in contract is reviewed for all youth discharged by discharge placement.
 - b. Length of stay in contract is reviewed for all youth remaining in the program.
 - c. Reentry to custody of youth completing the program is reviewed.

I. Reporting, Compliance, Corrective Action Plans

1. *The agency must have a current and valid required license for the level of services provided. Failure to have the appropriate licenses is a breach of contract and can ultimately result in closure of the agency.*
2. The agency must comply with submission of required reports, site visits, and data requests in a timely and accurate manner.
3. Appropriate action to eliminate or ameliorate identified problems in the agency's program of service is taken including
 - a. revision of policies and/or procedures;
 - b. changes in personnel assignments;
 - c. changes in in-service training; and
 - d. addition or deletion of a program or service.
4. The agency defines, systematically obtains, and maintains in retrievable form the information it needs to plan for and evaluate its program of services.
5. Information is obtained that, in the aggregate, describes

- a. referral sources, clients served, services provided, services needed but not provided;
 - b. applicants not accepted for services, the services requested, the reasons
 - c. clients who drop out of treatment or terminate services and their reasons for doing so.
- 6. The agency's board establishes policies governing access to client records by auditing, contracting, and licensing or accrediting personnel.
- 7. The agency ensures the retention and maintenance of records for a minimum of seven (7) years past the child's twenty-second birthday.
- 8. Corrective Action Plan Process
 - a. The office of Program Accountability Review (PAR) will issue a PAR report after a review of the provider agency and send a letter to inform the agency of its findings. If a Corrective Action Plan (CAP) is needed, the provider agency is instructed in this letter to submit the CAP to the attention of PAR within **thirty (30) calendar days** of the date of the letter. All findings identified in the PAR report must be addressed in the CAP.
 - b. PAR will review the CAP within 15 working days of receipt, and a certified letter will be mailed to the agency indicating if the CAP has been accepted or not accepted. If the CAP is not accepted, the agency will be given **seven (7) calendar days** to submit a corrected CAP unless otherwise noted. PAR will review the CAP again and notify the provider agency if the plan is now acceptable or not acceptable.
 - c. When the CAP is approved by PAR, or when CAP approval needs further consideration in part or whole, the CAP will be forwarded to the PTQ Green Team for final review and approval. With the PQT Green Team final approval of the CAP, an approval notice will be sent to the Agency.
 - c. If the provider agency does not submit a CAP within the listed time requirements, or if the corrected CAP does not adequately address all areas of the PAR findings, the PQT Green Team will be convened to discuss agency lack of responsiveness and next steps to be taken with the agency. Possible next steps may include, but are not limited to, an agency freeze, termination, or exercising contractor rights under the breach of contract language.

J. YOUTH ADJUDICATED DELINQUENT

- 1. Youth adjudicated delinquent and committed to DCS as a result of a felony offense(s) and youth having a history of convictions for felony offenses shall not

be placed in family resource homes prior to having received residential treatment unless the committing juvenile court has been notified of the planned resource home placement and the deputy commissioner for Juvenile Justice Programs or his/her designee has approved such placement.

2. Step-down and placement in a family resource home may be made following a period of residential treatment without notification to the committing court or approval from the deputy commissioner/designee.
3. Youth adjudicated delinquent and committed to DCS as a result of misdemeanor offenses and in the absence of prior felony offenses may be placed in family resource homes following notification of the committing court.

K. CHILD AND FAMILY TEAM MEETINGS

DCS Policy 31.7 Building, Preparing and Maintaining Child and Family Teams

<http://www.tennessee.gov/youth/dcsguide/policies/chap31/31.7Building,PreparingandMaintainingChildandFamilyTeams.pdf>

1. The Child and Family Team Meeting (CFTM) shall be the model utilized by DCS staff to engage families in the decision-making process throughout their relationship with the department. This model will be utilized for the development of case plans and making permanency decisions as well as for addressing critical decisions around the placement of children.
2. CFTMs are expected to be held at the following intervals:
 - a. within seven (7) days for children not entering care via Child Protective Services;
 - b. within thirty (30) days of commitment;
 - c. at the 15-day, 6-month, and 9-month points;
 - d. prior to placement moves (planned or unplanned);
 - e. to determine changes in permanency goals; and
 - f. just prior to discharge.
3. A CFTM will be held at least six (6) months prior to the 18th birthday to examine transitional or independent living services.
4. A CFTM is required, with notice to all involved adults and the child, if age twelve (12) or older, prior to reduction, change, or termination in level of services. When discharge/termination is being planned, the CFTM must be convened no later than ten (10) days prior to discharge from custody.

5. CFTMs do not apply to the agency's ongoing treatment planning meetings unless specific criteria in the paragraph above are addressed.
6. Provider agencies may request that DCS convene a CFTM; however, only DCS staff can convene a CFTM. Provider agencies need to keep copies of correspondence requesting a CFTM. A CFTM must be held within ten (10) days of the request when not being convened for emergency purposes. Whenever post-custody services are being offered, *provider agencies* have the authority to convene a CFTM.
7. Scheduling/notification of a CFTM can occur by telephone or in writing. If notification is by telephone, the CFTM must occur within seven (7) days.
8. When the permanency plan is completed, the plan serves as the documentation of the child and family team's work. For all others, the team's work and decision(s) are documented in the staffing summary and justification form.
9. Failure to comply with the policy regarding the use of Child and Family Team Meetings (CFTM) for the disruption or movement of a child shall result in penalties as determined by the State for each day the child resides in a placement not approved through a CFTM. The private provider shall not be penalized if documentation can verify the provider's efforts to coordinate a CFTM with DCS before the disruption or movement of the child.

L. CASELOAD SIZES, VISITATION REQUIREMENTS, AND FAMILY SERVICES

1. Caseload Sizes

- a. Where the provider case manager role mirrors that of the DCS family services worker, the case manager should have a caseload of 20 or less. For case managers working with medically fragile or therapeutic foster children, the caseload should be 10 or less.
- b. When the provider case manager's caseload consists of a mix of children and youth in regular foster care and those in medically fragile or therapeutic foster care, the caseload size should be weighted accordingly and the ratio adjusted.
- c. To determine the weighted caseload, one medically fragile or therapeutic foster child equals two children in regular foster care. For example, a case manager could have eight therapeutic/medically fragile and four regular foster care children.
- d. At no time can a case worker with medically fragile or therapeutic foster care children have a weighted caseload that would exceed the maximum caseload size for those services.

- e. Each provider agency casework supervisor shall supervise no more than five case workers.
- f. Provider agencies shall establish a process for reassigning cases to ensure coverage at all times and to maintain the continuity of agency case management without interruption by:
 - 1. Reassigning cases within one (1) business day of the departing agency worker leaving employment.
 - 2. Arranging a face to face meeting between the departing agency worker and the receiving worker, unless there is a documented emergency or the agency worker leaves without notice.
 - 3. Making a determined effort to have the departing agency worker introduce the receiving agency worker to the child and family.

2. Visitation

16.38 Face-to-face Visitation with Dependent and Neglected and Unruly Children in DCS Custody and Attachment

<http://www.tennessee.gov/youth/dcsguide/policies/chap16/16.38%20Face-to-Face%20Visitation%20with%20Dependent%20and%20Neglected%20and%20Unruly%20Children%20in%20DCS%20Custody.pdf>

16.43 Super/unsupervised Visitation between Child-Youth, Family and Siblings

<http://www.tennessee.gov/youth/dcsguide/policies/chap16/16.43%20Super%20Unsupervised%20Visitation%20Between%20Child-Youth,%20Family%20and%20Siblings.pdf>

For children in a foster home or facility operated by a contract agency, DCS shall require and ensure that the private agency case worker visits the child as frequently as necessary to ensure the child's adjustment and progress in placement. The above-referenced DCS Policies give in-depth instructions as to the minimum requirements of case worker visits and visits between the child and his family. See the *Visitation Protocol Attachment to 16.38 Face to Face Visitation with Dependent and Neglected and Unruly Children in DCS Custody* for a chart detailing the requirements.

If a child moves to a new placement at any time following his/her initial placement, the child shall be visited as if he/she were just entering care. The initial face-to-face visit at the time of placement may be counted toward the three required visits.

The DCS family services worker must have at least one contact each month with the provider agency's case worker to obtain information regarding the

child's progress.

Providers must report all face-to-face (F2F) visits through the DCS F2F Web application. F2F Application Protocol

a. **Dependent, Neglect, and Unruly Adjudication**

Providers will document two (2) "Private Provider – Family/Sibling Visitation F/F" visits per month and provider has to associate at least one family member for the recording as contact information.

Providers will document one (1) "Private Provider – Family/Sibling Visitation F/F" visit per month and provider has to associate at least one sibling for the recording as contact information.

b. **For Juvenile Justice Class Children**

Providers will document one (1) "Private Provider – Face to Face with Client" case worker visit per month until the child exits care or leaves the agency. This would exclude all detention center placements.

c. **Additional Provider Requirements for All Custodial Children**

1. Providers will document all face-to-face contacts before the last day of the following month. Example: If meeting took place on 1/3/07 provider must document and complete the recording by 2/28/07.
2. Provider will not be required to enter unsuccessful visitation attempts.
3. Providers will have the ability to print agency's face-to-face documentation.
4. Providers will have the ability to enter multiple face-to-face contacts per child documentation session within the application.
5. Providers will discontinue sending monthly visitation spreadsheet information via the EIRSM mailbox.
6. Provider will only enter quantifiable data into the application. No narrative case detail information is necessary in this application.
7. The creator of the face-to-face documentation will have the ability to "Mark in Error" if the documentation was entered incorrectly as long as the recording marked as "Complete" is accompanied by an explanation. Provider can delete face-to-face documentation that has not been marked "Complete." Providers will then need to reenter the correct visit within the last day of the following month.
8. If a DCS family service worker and a provider case worker attend a

visit together, each agency (DCS and the contracted provider) will document the visit separately allowing each agency to gain credit for the visit. OIS will have the ability to filter the visit and allow DCS to bill for TCM as well as allowing for the provider to count the visit toward Brian A. visitation requirements.

9. Providers must submit monthly summaries to the SAT coordinators.

10. **F/F Functional Field Requirements**

- a. **“Occurred Date.”** Date Face-to-Face visit occurred.

- b. **“Type of Contact.”** Providers will choose from the following drop down box choices:

Private Provider – Face to Face with Client. (Only use when the provider meets with the client)

Private Provider – Family/Sibling Visitation Face to Face. (Only use when the provider meets with the family and/or sibling)

Private Provider – Family/Sibling Visitation not Face to Face. (Only use when the provider was NOT present in the meeting but client and one other family member was present)

- c. **“Location of Contact.”**

Providers will choose from the following drop down box choices:

- d. **“Person(s) Contacted.”** Providers would use either “client” or “family.” Upon selecting “client,” TNKIDS will populate the client’s name. Upon selecting “family,” the system will pre-populate from the TNKIDS “Person” tab and pull up all applicable family members.

- e. **“Name of Person(s).”** Name listing of all persons participating in the visits. A drop-down box will be pre-populated from the TNKIDS “Person” tab as related to the child. (If name does not appear, please contact your DCS family services worker and request to add the name to TNKIDS case file.)

- f. **“Was a DCS employee present during the face-to-face meeting?”** (Check Box) If checked, it signifies that a DCS family services worker participated in the visit.

- g. **“Was this face-to-face meeting done on behalf of another user?”** (Check Box) If checked, it signifies the visit is being entered by someone other than the provider case worker. This will allow provider data entry to enter the provider staff name that conducted the F/F.
- h. **“Recorded for Name.”** This is a “Text box” to record the provider name, who met with the client F/F visit.
- i. **“Was the client’s sibling(s) present during the face-to-face meeting?”** Drop down “yes or no” box that will allow the provider to link the F/F case recording to the client’s siblings provided the sibling is also a client in TNKIDS.
- j. **“Sibling name(s).”** List of client’s siblings provided there is a sibling record existing in TNKIDS associated to the client. Provider required to choose a sibling if #9 is answered with ‘Yes.’
- k. **“Completed” Face-to-Face Case recording.** Check box to indicate the recording was legitimate and took place.

3. Family Services

- a. Services are provided to children in order to meet their permanency needs. Each child served is
 - 1. prepared for a placement outside the home and helped with conflicts about the placement and separation from family members;
 - 2. encouraged to maintain contact with the biological family and provided with support in making such arrangements, unless specifically contraindicated because of the child’s safety;
 - 3. provided information about parents’ activities and progress toward the goal of returning home, unless home is not a possibility;
 - 4. provided with assistance in maintaining the relationship with siblings through visits and shared activities; and
 - 5. prepared for return home, adoption, or for placement in a stable, nurturing environment that is to be permanent and when this is not possible,
 - 6. prepared for independent living and helped to identify significant adults with whom relationships can be maintained.

- b. When a child is in out-of-home care, the agency fully involves the family, or individuals identified in the permanency plan as permanency options, with a focus on timely permanency as the primary goal.
- c. Unless the child's safety would be compromised, the agency makes intensive efforts to engage parents in continuing contacts with their child and in implementing the plans for permanency for the child.
- d. The family of a child in out-of-home care participates in making case plans, is kept advised of ongoing progress, and is invited to case conferences.
- e. The agency designs and implements service in a manner that supports and strengthens family relationships and empowers and enables parents and family members to assume their roles.
- f. A written plan of family involvement, as part of the treatment plan, shall be developed at intake and updated no less than quarterly between the agency and the custodial department and will address but not be limited to the following issues:
 - ☐ visitation guidelines and/or restrictions
 - ☐ agency responsibility for working with the family
 - ☐ state agency responsibilities for working with the family
- g. The agency provides coordination of social services to children, adults, and families that may be necessary to achieve family reunification, stabilize family ties, or obtain a permanent family for a child receiving out-of-home care.
- h. Services are provided to the child's parents to enable them to plan for the child's return home or for a permanent nurturing family for their child.
- i. Services are provided to help the child's parents maintain and enhance parental functioning—parental care, the maintenance of parental ties, or, when in the best interest of the child, termination of parental rights.
- j. Services are provided to improve parenting skills as determined by the permanency plan and will include a written plan of action developed during a CFTM to outline the unique needs of the family. Skills improvement may be addressed during family counseling sessions or in classes depending on assessment of the family needs. Families will not be required to pay for training.
- k. Visitation between the child and family, siblings, and others identified in the child's permanency plan must be flexible and coordinated as outlined by the CFTM.
- l. Family involvement guidelines include any individual(s) identified in the permanency plan or as a result of a CFTM who are identified as a permanent or discharge option for the child.

1 - CORE STANDARDS

- m. The provider agency cannot deny visits, telephone calls, or mail contacts with family members approved by DCS.
- n. Sibling groups in the legal custody of DCS shall be provided with opportunities to visit with one another if they are not placed in the same foster home, group home, or other residential facility unless there is a court order prohibiting such visitation. Such restrictions must be documented in the case record by the signed court order.
- o. Visits shall be for no less than one hour in duration unless the visit is shortened to protect the safety or well-being of the child. Visits should be as long as possible to support the ongoing relationship of the children and may include overnight or weekend visits.
- p. Visits must be scheduled as often as possible but no less than 4 hours a month.
- q. Visits shall take place in the parents' home, the resource home in which one of the siblings is living, the home of relatives, or the most homelike setting otherwise available.

M. CHILD ABUSE REPORTING

- 1. **Tennessee law (T.C.A. 37-1-403) requires that any person having knowledge of child abuse is to report this immediately.**
- 2. Any report of suspected abuse or neglect of a minor child must be reported to DCS.
 - a. **The telephone number to report is 1-877-237-0004.**
 - b. Reports are to be made immediately.
 - c. Reports can be made twenty-four hours a day, seven days a week.
 - d. (ref. DCS Policy at www.state.tn.us/youth/policies/Chapter%2014%20Child%20Protective%20Services/14-02%20Child%20Protective%20Services%20Intake%20Decisions.pdf)
 - e. **DCS Policy 14.15 Reporting False Allegations of Child Sexual Abuse** <http://www.tennessee.gov/youth/dcsguide/policies/chap14/14.15%20Reporting%20False%20Allegations%20of%20Child%20Sexual%20Abuse.pdf> gives information on false allegations.
- 3. Further, the legislature has given DCS the power to investigate without hindrance all reports of abuse or neglect and directs "any child care program or child care agency" to grant access to premises, children, and records, regardless of whether or not the child is in the custody of the Department of Children's Services (T.C.A. 37-5-512). The department is also empowered to

take “certificate or licensing action” to prevent agencies or persons from continuing in any capacity in which harm may occur.

4. While the need for agencies to gather necessary information in order to make the report is recognized, agencies are prohibited from conducting an independent investigation into the validity of the report.
5. If the agency is making the report, the screening/assignment decision will be reported to the agency within twenty-four (24) hours.
6. The agency is responsible for the safety of children they serve. The agency must make a safety plan for the child while awaiting the screening/assignment decision.
7. If the report is assigned for investigation, the safety plan will remain in effect until agreement between agency and Special Investigative Unit (SIU) is reached. For information DCS Policy 14.25 Special Investigations

<http://www.tennessee.gov/youth/dcsguide/policies/chap14/14.25%20Special%20Child%20Protective%20Services%20Investigations.pdf>

8. During the investigation, the agency will cooperate fully with SIU. Investigations will be completed within sixty days (see DCS Policy 14.5 at www.state.tn.us/youth/policies/Chapter%2014%20Child%20Protective%20Services/14-05%20Investigation%20of%20Alleged%20Child%20Abuse%20and%20Neglect.pdf). If an investigation cannot be completed within the required time frame due to extenuating circumstances, the agency will be informed.
9. Incident reporting requirements also pertain to child abuse/neglect complaints.

N. INCIDENT REPORTING

DCS Policy 1.4 Incident Reporting

<http://www.tennessee.gov/youth/dcsguide/policies/chap1/1.4%20Incident%20Reporting.pdf>

DCS Policy 31.2 Responsibilities Regarding Runaways, Absconders and Escapees

<http://www.tennessee.gov/youth/dcsguide/policies/chap31/31.2ResponsibilitiesRegardingRunawaysandEscapees.pdf>

Incidents are child-specific indicators that alert DCS and provider agencies to potential risk to children in their care. **Providers must report all incidents through the Serious Incident Reporting Web-based application on the DCS Intranet within 24 hours of the incident occurring. If the application is not available, the provider must fax the information to: The DCS Evaluation and Monitoring Division at: (615) 532-5723.**

1. All SIRs (listed below) are reported via web-based interface and all data will be tied to TNKIDS client IDs.
 - ☐ Abduction-A child or youth is taken from the facility by unauthorized individuals (i.e. alleged perpetrators of abuse, non-custodial parents or relatives).
 - ☐ Abuse or neglect-A DCS or contract agency staff member or any person in contact with the youth is alleged to have physically, sexually or verbally abused a child or youth.
 - ☐ Contraband-Any item possessed by an individual or found within the facility that is illegal by law or that is expressly prohibited by those legally charged with the responsibility for the administration and operation of the facility or program and is rationally related to legitimate security, safety or treatment concerns.
 - ☐ Major Event at Agency-An event causing a significant disruption to the overall functioning of the program and necessitating notifying an emergency official. This event affects all, or nearly all, of the children and staff at the location. Examples include riot, fire, death of a child or staff member (while at the location), a flood, etc.
 - ☐ Arrest of child or youth-A child or youth is arrested while in the custody or control of DCS, and the arrest has been confirmed by a law enforcement agency
 - ☐ Assault-A willful and malicious attack by a child/youth on another person (This is not meant to include horse-play.)
 - ☐ Arrest of parent, surrogate or staff person-The arrest of a DCS or a contract agency staff member, including foster parent or others affiliated with the youth and /or family and has been confirmed by a law enforcement agency
 - ☐ Runaway-Child or youth leaves a program without permission and their whereabouts is unknown or not sanctioned
 - ☐ Placement Referral Decisions-placement referral decisions
 - ☐ Disruption of Service-disruption of service
 - ☐ Emergency Medical Treatment-A child/youth has been injured or has suffered an illness that requires emergency medical attention. (In an instance of treatment of a child or youth, the child or youth's custodial adult must be notified.)
 - ☐ Medication Error-A medication error is when a medication is not administered according to the prescribing provider and /or according to DCS policy and procedure.
 - ☐ Emergency Use of Psychotropic Medications(s)-An emergency one-time

dose of a psychotropic medication in the event of a psychiatric emergency when all other measures have been determined unlikely to prevent the child/youth from imminent harm to self and /or others

- ☐ Mechanical Restraint- The use of a mechanical device that is designed to restrict the movement of an individual. Mechanical restraints shall be defined as handcuffs, chains, anklets, or ankle cuffs, or any other DCS approved or authorized device.
 - ☐ Seclusion-The placement or confinement of an individual alone in a locked room or egress is prevented
 - ☐ Physical Restraint-The involuntary immobilization of an individual without the use of mechanical devices This includes escorts where the youth is not allowed to move freely.
 - ☐ Mental Health Crisis-A child or youth has engaged in or experienced: self injurious behavior; suicidal ideation or behavior; homicidal ideation or behavior or acute psychotic episode.
2. Provides incident information to enhance quantitative and qualitative data capture as well as reporting;
 3. Captures incident types and categorizes as Level 1 to 4 based on a risk assessment definition with 4 being the most severe;
 4. Sends notifications and screen displays that will be generated to targeted groups who respond in a timely and efficient manner;
 5. Will have secure data entry and reporting which will be visible by regions and/or provider agencies;
 6. Reports can be generated and used as a management tool for provider agencies, DCS regional and Central Office staff.

The following link goes directly to the SIR online training website.

www.tntraining.us/moodle/course/category.php?id=5

O. ALLOWANCE, CLOTHING AND INCIDENTALS

1. The provider shall set aside a minimum of \$1.00 per day for each child in the program as the child's personal allowance.
2. This requirement does not apply to detention centers or emergency shelters. Also, continuum providers have the option of continuing to give the child an allowance once the child is placed in his/her own home.
3. The child's personal allowance is included in the per diem rate reimbursed by the state to the provider.
4. If at all possible, a child should be allowed to manage his/her money, choose how the money is spent as long as it does not violate law or program policy, and

have access to pocket money.

5. The provider must track the allowance in such a way that the child's allowance account reflects the date of the child's admission to the provider's program and debits and credits to the account and maintains a running balance showing the amount of allowance money the child has at any one time.
6. The provider must maintain a separate log for allowances, identifying the child's full name. Allowance credits should be initiated upon a child's entrance into the provider's program. Allowance debits by amount are to be recorded on the date of the transaction with accompanying signature of the child or two signatures of a witness in the event that the child is unable to sign for himself/herself.
7. The allowance follows the child and is the property of the child. When a child leaves the agency's program, the agency should submit allowance funds in the total amount to the child. In the case of the death of a child, the money will be returned to the state.
8. When the child leaves the facility, a check will be made out to the child to cover the allowance balance and the child's allowance account will be closed and a description for "zero out allowance" will be printed on the child's account.
9. The child's allowance cannot be used to purchase items that become the property of the agency, for normal age appropriate hygiene items and/or clothing needs, for items that are an inherent part of the agency's program including special clothing required by the agency, or for program planned outings. However, children can use their own allowances for extras while on these outings and may purchase their own clothing if they do not wish to use clothing provided by the agency.
10. The child's allowance cannot be withheld as a form of punishment. Restricting use of allowance must be pre-approved by a CFTM.
11. A portion of the child's allowance may be applied toward the cost of restitution for damaged property as long as it is approved by the CFTM.

CLOTHING AND INCIDENTALS

1. All children who enter state custody are eligible for an initial clothing allowance if clothing is unavailable or inadequate. Additional clothing purchases may be approved if clothing is lost during moves from one placement to another or in case of fire or other natural disaster. The DCS family services worker is responsible for authorizing the purchase of clothing in these situations.
2. The provider agency is responsible for routine and ongoing clothing purchases after the child enters the program. Clothing purchases are included in the provider's per diem rate.

3. Clothing is the property of the child and moves with the child when the child leaves the program. Clothing left behind when the child is moved must be moved by a DCS representative within 30 days.
4. The provider agency must supply any special clothing required for the child to participate in a certain program.
5. The provider is responsible for program and normal age-related personal incidental costs for children in the program such as bedding, camping equipment, diapers for infants, toiletries, personal hygiene items for females, etc.

P. INTERDEPENDENT LIVING SERVICES

Eligible teens and young adults in foster care ages 14–21 **must** be offered assessment, skills training, counseling, education, and other appropriate support and services to assist their transition to self-sufficiency. Agencies have the responsibility for teaching skills necessary for youth to become self-sufficient and for providing opportunities to use those skills within a supportive environment. Interdependent living skills training is incorporated into all levels and types of care. The skills are age and developmentally appropriate to the child and family treatment needs.

This shall be reflected in the youth's individual treatment plan.

For assistance in beginning the assessment of needs for interdependent living skills, providers may contact the DCS Regional Interdependent Living Coordinator.

For more in-depth information on services and policies, please refer to Section Two, V Interdependent Living Services.

Q. EDUCATIONAL STANDARDS FOR DCS PROVIDERS

The provider will ensure that the educational needs of students are thoroughly assessed and that appropriate educational opportunities are provided according to DCS Policy. Whenever possible, children/youth in custody should attend public schools. The provider will maintain a contact and liaison with the local education agency. In situations where it has been determined that the child/youth will attend an in-house school, the provider will contract with or provide appropriate services.

ATTACHMENT NINE provides in-depth information on serving the educational needs of youth in care including hyperlinks to appropriate DCS Policies.

R. REFERRAL PROCEDURES AND APPEALS

1. Children Served

Only children referred by the regional placement services group (PSD) who meet the criteria as specified in the definition of services of the DCS Provider Agreement will be served. The provider MUST accept referrals that meet the criteria outlined in the scope of services. Determinations regarding the order of admission are subject to the discretion of DCS staff. Providers will be held accountable for refusing to accept appropriate referrals.

2. Referral Packet Information

- a. Referrals will contain certain information and will be forwarded to the residential provider agency with an attached cover letter. The referral packet will contain the following:
 1. cover letter;
 2. the Family Functional Assessment and/or social history with any addenda and revisions to include behavior and placement summary for the last six months;
 3. critical medical information, the needs of the child for any ongoing medical treatment, current prescription (and other) medication the child is taking;
 4. any “zero tolerance” issues that may exist;
 5. psychological assessment, if appropriate; and
 6. permanency plan packet including any revisions. (The permanency plan packet includes the permanency plan, attachment of Notice of Equal Access to Programs rights, attachment of Appeal Rights [for appeals within the region], and attachment of Notice of Termination Procedures. The new Notice of Action and the TennCare Medical Care Appeal form should be attached.)
- b. Agencies should admit emergency referrals without referral packets or with incomplete referral packets with information forwarded immediately as available by regional staff. To this end, all agencies are required to provide to their respective program coordinators in the DCS Child Placement and Private Provider Division emergency contact information for their gatekeeper. The gatekeeper must be available 24/7 and must be empowered to make placement decisions.

3. Time Limit to Accept Referral or Appeal—Appeal Procedure

- a. The provider will, within four (4) hours of receiving a referral packet, respond to the request for service(s).
- b. If the provider determines that the referral is not appropriate and, after discussion, the referring RRMG maintains that the referral is appropriate, the provider may appeal the referral to his/her RRMG appeals

committee immediately or no later than one working day after packet receipt.

- c. If the appeal is not filed within this time frame, the provider must accept the referral.
- d. The appeal must be in written form, including
 - 1. the name of the referred child,
 - 2. the RRMG seeking placement, and
 - 3. the specific characteristics of the child determined by the provider to be beyond the scope of services as outlined in the agreement.
- e. The provider must send a copy of the referral packet to the RRMG appeals committee along with the written appeal.
- f. The referring region will have the responsibility of providing a written rebuttal to the RRMG appeals committee including the name of the child and why the region deemed that particular scope of service to be inappropriate for the child. Supporting documentation must be included in the letter.
- g. Appeal procedures are to be carried out uniformly statewide utilizing standardized procedures, selection of members of the region appeals committee, service terms, election of chairperson, voting members, establishment of a quorum and meetings for the appeals committee, paperwork needed to make an appeal, appeals committee process and routing, and maintenance of statistical data concerning appeals.
- h. The appeals committee will meet within five (5) working days of receiving the appeal and is responsible for conducting a review and providing a written and final decision regarding the appropriateness of the referral. The appeals committee will make a decision on the appeal based on the information received from the provider and in accordance with the Provider Policy Manual. The chair will notify all concerned parties by telephone following the decision and will follow-up with a letter regarding the appeal decision within 24 hours to DCS, the provider, and the resource placement specialist.
- i. The RRMG appeals process differs from the TennCare appeals process in that the RRMG was developed to resolve issues arising when a provider or DCS are not in agreement regarding whether the provider is appropriate to serve the needs of the child. The TennCare appeals process is to be used when someone (a child or someone on behalf of the child) disagrees with the level of care determination, and therefore appeals this as a denial, delay, reduction, suspension, or discontinuation

of TennCare services. The person appealing in this kind of case would believe the service to be medically necessary. To learn more about the TennCare appeals process, please go to

www.state.tn.us/youth/policies/chapter11.htm.

- j. RRMG will track all rejections through the SIR Application.

4. **Appeals Process for Regions without the RRMG Appeals Committee**

- a. For those regions for which there is no standardized appeals process through the RRMG, the following shall apply:
 - 1. The provider may appeal any referral viewed as inappropriate to the Division of Child Placement and Private Providers.
 - 2. The appeal must be in written form and forwarded to the division immediately or no later than one (1) working day after packet receipt.
 - 3. Documentation should include the name of the child, the region seeking placement, and the specific characteristics of the child determined by the provider to be beyond the scope of services as outlined in the agreement.
 - 4. The provider must send a copy of the referral packet to the Division of Child Placement and Private Providers along with the written appeal.
- b. The region will have the responsibility for providing a written rebuttal to include:
 - 1. the name of the child and why the region has deemed the child to be appropriate for that particular scope of services; and
 - 2. supporting documentation with the letter.
- c. A committee of core leadership will be convened within five working days of the receipt of the appeal and is responsible for conducting a review and providing a written and final decision regarding the appropriateness of the referral.
- d. The committee will make a decision on the appeal based on the information received from the provider and the region.
- e. All parties will be notified by telephone immediately following a decision, and a written response will be issued within 24 hours.
- f. If a vacancy exists in the provider's program at the time an appeal is made or being reviewed, the RRMG has the discretion to hold placement of any other referrals until the appeal is resolved.

- g. The provider will be responsible for any pre-admission visits to the child in the child's current placement.

S MAINTENANCE OF WAITING LIST, AUTHORIZATION FOR SERVICES AND ADMISSION PACKET

1. The RRMG has the responsibility to maintain the regional waiting list for the provider's program. Special classes of children/youths may be identified as priorities for waiting lists. The regional staff determines the next admission for openings from the waiting list.
2. Authorization for services
Admission can occur only when the appropriate regional resource placement specialist authorizes the client in TNKids financials. The provider may print an authorization from the application if needed.
For more information regarding TNKids Financials, see www.state.tn.us/youth/providers/index.htm.
3. Admission Packet. The following information will be included in the packet:
 - a. school records, including special education records
 - b. immunization records
 - c. court order(s)
 - d. birth certificate
 - e. Social Security card
 - f. insurance information—MCO/BHO identification numbers (if not available, a copy of the TennCare application is required)

T. SUPPORT FOR FAMILY RELATIONSHIPS

1. The agency designs and implements service in a manner that supports and strengthens family relationships and empowers and enables parents and family members to assume their roles.
2. When a child's presenting problem affects or is affected by a client's family, other family members are offered service or are included in service planning.
3. The agency provides coordination of social services to children, adults, and families that may be necessary to achieve family reunification, stabilize family ties, or obtain a permanent family for a child receiving out-of-home care.
4. The family of a child in out-of-home care participates in making case plans, is kept advised of ongoing progress, and is invited to case conferences.

5. When a child is in out-of-home care, the agency fully involves the family or individuals identified in the permanency plan as permanency options with a focus on timely permanency as the primary goal.
6. The agency cannot deny visits, telephone calls, or mail contacts with DCS approved family.

U. CLIENT INFORMATION, INITIAL ASSESSMENT AND TREATMENT PLAN

1. **The agency collects the information it needs to deliver and monitor quality services while protecting the right to confidentiality of its clients.**
 - a. Client Information
 1. The agency follows its written policies and procedures that meet applicable legal requirements, if any, governing the collection and maintenance of client information essential to the provision of its services.
 2. The agency maintains for each individual client, family unit, or group receiving service a record of such essential information as is deemed necessary to provide appropriate services, protect the agency, or comply with legal regulation. Each record is organized into sections and includes a table of contents so that all documents within the record are readily accessible.
 3. The record for an individual client contains, at a minimum, the following information:
 - (a) biographical or other identifying client information;
 - (b) the nature of the client's problem or reason for requesting or being referred for services;
 - (c) the service plan; and
 - (d) services provided to the client by the agency or through referral.
 - b. Basic client information is supplemented by the following:
 1. psychological, medical, or psychosocial evaluations;
 2. court reports;
 3. documents of guardianship or legal custody, birth or marriage certificates, and any court orders related to the service being provided;

4. financial information used to establish fees; and
 5. documentation by the agency of ongoing services to the client.
 - c. The record contains a copy of the written order for medications or special treatment procedures when directly prescribed by the agency or when administered directly by agency personnel to clients in a residential, day treatment, or day care facility.
2. Minimal Treatment Record Standards
- a. Department of Children's Services (DCS) treatment records compiled by DCS contract agencies must include the following information for each served child:
 1. cover sheet;
 2. initial assessment;
 3. treatment planning and implementation;
 4. progress notes;
 5. medical services;
 6. treatment documentation/case notes coordination of care documentation;
 7. other information; and
 8. release of information
 - b. Treatment records must be maintained for seven (7) years after the child's twenty-second (22nd) birthday.
 - c. All aspects of individual, group, and family treatment must be documented and meet the following minimum standards:
 1. written in clear and complete sentences;
 2. name and relationship to the child of each person documenting, with credentials, as appropriate for clinical service providers;
 3. all entries in records signed by the author and dated;
 4. entries legible to someone other than the writer;
 5. location of contact(s);
 6. beginning and ending times of the contact;
 7. purpose of contact, observations/assessments/clinical information, and next planned contact;
 8. identifying information for the client on each page;
 9. consecutive entries;

10. no white-out;
 11. no post-its;
 12. no stapled or loose pages in the record;
 13. consecutive entries and no blank spaces in the record;
 14. errors crossed out and initialed;
 15. use of black or blue ink; and
 16. approved/generally recognized abbreviations.
3. Initial Assessment
- a. The initial assessment contains information concerning the child's initial treatment needs, obtained upon placement. Information will come from referral packets, intake information, family members, previous placements, and information forwarded by the child's DCS home county family services worker. If any information is unavailable for any reason, the DCS contract provider's requirements will be deemed fulfilled if the record contains documentation of reasonable efforts to obtain the information.
 - b. Within thirty (30) days of placement, information related to the initial provision of appropriate clinical services will be included in the client's treatment file. This information shall include
 1. a description of the child or youth's general physical and mental health status at the time of intake;
 2. a psychiatric history that includes a description of the child's presenting clinical/psychiatric issues, risk factors, psychiatric symptoms, a five-axis diagnosis of mental illness using the most current edition of DSM (if completed and available), and any history of alcohol and drug abuse;
 3. a summary of medical history that includes medical problems, alerts, present medications, and medication history;
 4. Family Functional Assessment;
 5. a general evaluation regarding the youth's functioning in the domains of community or family support; educational activities/status; family status and involvement; current physical health; emotional/behavioral health; substance abuse evaluation or risk; risk factors for suicide, runaway, violence, or sexual behaviors; and
 6. an assessment or review of strengths, potential permanency goals, personal goals, and projected needs.

- c. The initial assessment will be augmented and revised as complete information and assessment is available.
- 4. Treatment Planning and Implementation
 - a. Treatment Planning and Implementation
 - 1. Each agency shall develop structures that allow for comprehensive treatment planning, implementation, and evaluation.
 - 2. The development of the treatment plan shall be completed using the Child and Family Team model within the first 30 days of admission to the program.
 - 3. The treatment plan is a dynamic document and is in a constant state of change. The plan changes to reflect the course of treatment whether there is progress or regression.
 - b. Treatment Plan and the Permanency Plan
 - 1. Using information from the youth's Permanency Plan (developed by DCS FSW) as well as from the following shall develop the Treatment Plan:
 - (a) Assessments—those recently completed as well as others from past treatment or services
 - (b) Clinical discussions and observations
 - (c) Any medical information—The inclusion of medical information into the treatment plan will depend on the nature of the child's condition. For medically fragile children with minimal or no mental health concerns, the treatment plan would be dominated by medical concerns. For situations where the youth's medical condition may affect treatment for mental health issues, the treatment plan should reflect the necessary interdisciplinary approach.
 - (d) Any school information
 - (e) Other information as necessary
 - (f) Past treatment involvement
 - (g) Unique needs of youth and family
 - 2. Treatment plans must also be based on the following information:
 - (a) Medical necessity and need for outpatient therapy and treatment.

- (b) Consideration of service(s) needed for either mental health case management, Continuous Treatment Team services (CTT), or Comprehensive Child and Family Treatment (CCFT) as appropriate. This may include need for said services as youth is transitioned out of facility.
- 3. The treatment plan helps in the revision of the DCS Permanency Plan always providing information as to the progress or lack of progress of the youth and family.
- c. **Treatment Areas**
 - 1. All treatment plans should include, at a minimum, the following treatment areas:
 - (a) Emotional/Behavioral
 - (b) Education/Vocational
 - (c) Health/Medical
 - (d) Social/Independent Living/Recreation
 - (e) Family
 - (f) Discharge Planning
 - 2. Other areas such as alcohol/drug treatment and sexual perpetrators may fall under the emotional/behavior category.
 - 3. The broader category of Social/Independent Living/Recreation may be broken down into individual categories of Social, Independent Living, Recreation/Leisure.
 - 4. The treatment plan includes specific interdependent living and self-sufficiency skills for youth ages 14 and older.
- d. **Treatment Plan Components**
 - 1. **A treatment plan** is a well-organized, well-written document that can be read and understood by all members of the treatment team.
 - 2. While there are individual treatment areas that may be implemented by various professionals, the treatment plan provides the team with what is to be accomplished in the treatment process.
 - 3. **Goals** – An effective treatment plan begins with **goals**.

These goals are global in nature and provide direction and outcome as to what is to be accomplished. Each area may have a number of goals. However, there should be at least one (1) goal for each treatment area.

4. **Objectives** are smaller in nature and more descriptive in terms of what the youth or family is to actually do in the process.
 - (a) Objectives are measurable, allowing an independent observer to view the youth involved in an objective and then being able to determine if in fact the youth accomplished the expectation.
 - (b) There is usually action associated with the objective. For example, the statements below help understand the objective:
 - The youth will demonstrate...
 - The youth will recite...
 - They youth will communicate...
 - (c) There can be more than one (1) objective for a goal. However there must be at least one (1) objective listed or defined for each goal written.
5. **Frequency/Time Frames, Interventions, and Responsible Individuals**
 - (a) Once the objective has been determined, the treatment plan must then contain the frequency (how often, how many times) the youth is to engage in the objective to be successful.
 - (b) Next, the types of interventions that may be used to be able to achieve the objective are listed.
 - (c) Finally, the person who is going to be responsible for the objective is listed. This individual keeps track of or records how the youth responds or works toward accomplishing the objective. An objective can have multiple people involved or listed on the treatment plan.
 - (d) The treatment plan shall include a time frame for the projected completion of specific goals and objectives.

6. Signature Page
 - (a) Each treatment plan shall include a signature page. This page contains the signatures of those individuals who have been involved in the treatment planning process.
 - (b) The listed signatures are the agreement by all parties that they agree to the plan and its components. The youth (when appropriate based on age and youth's level of comprehension) and family's signatures need to be on the signature page.
7. Treatment progress Notes are submitted monthly to the DCS case manager and resource care manager. They include, at a minimum
 - (a) Description of child/family strengths, progress and limitation in achieving treatment plan goals with intervention plans for barriers for achieving goals.
 - (b) Observations, assessments, intervention, and planned interventions.
 - (c) Discharge notes must document achievement of goals or necessary referral to assist in the final attainment of goals.
 - (d) A discharge summary within fifteen (15) days of discharge. Documentation should include discharge reason and discharge placement (recommendation).
8. Treatment Plan Review
 - a. The organization develops and regularly reviews the treatment plan for each youth on a regular basis. This is usually monthly. Revisions will be documented and communicated to all parties on the team.
 - b. While a child and family team meeting does not have to be called to review the treatment plan, the agency can request one or invite the family and other treatment team members from outside the agency. (Legal personnel, DCS family services worker) The youth should be part of the treatment

plan review process.

- c. There should be a signature page with each treatment team meeting. The signatures account for attendance as well as agreement of the discussion and changes in the plan.
- d. Regardless of the agency's treatment plan review, the formal review and revision occurs through the Child and Family Team Meeting every three (3) months, or more often if the treatment needs change. Participants in the initial CFTM must be invited to all reviews.
- e. Documentation of the three-month treatment team review must be contained in the treatment plan portion of the treatment record. A signature page must accompany this review to indicate the meeting did take place with participant signature.

6. Doctor Notes/Medical Follow-up

Facilities must gather medication information on each child and maintain and update this information in the youth's treatment record. The medication information includes but is not limited to:

- (a) A medication sheet or progress note that includes documentation of current psychotropic medication with dosages and dates of dosage change(s);
- (b) Documentation of the child's education regarding possible side effects;
- (c) Documentation that the reason for medication was explained to the parent(s) and/or child (if age appropriate);
- (d) Documentation that a female youth of child bearing age is educated about taking psychotropic medication while pregnant, and females educated about Toxic Shock Syndrome;
- (e) Documentation of child's verbalization of understanding medication education (if age appropriate); and
- (f) Evidence that all DEA scheduled drugs (i.e., any drug listed on DEA Schedule I-IV) are avoided in the treatment of children with a history of substance abuse/dependency.

7. Coordination of Care Notes and Documentation
 - (a) Records should indicate other clinicians providing care and documentation of any communication. The record must demonstrate an ongoing coordination with any clinicians providing services and ongoing efforts to ensure continuity of care post discharge. Medical care must be coordinated with the primary care physician in the MCO.
 - (b) The provider is also responsible for maintaining appropriate releases and documenting any information that has been released.
 - (c) The provider should also document efforts to coordinate care with the home county family services worker and parent(s) and/or child (if appropriate). Provider must demonstrate that the home county case manager has approved the treatment plan and efforts have been made to ensure participation of all involved adults in the treatment planning.
8. Continuity of Care notes should contain:
 - (a) Progress notes that reflect the date(s) of appointments or any follow-up appointment(s)
 - (b) Documentation that the child is referred for and receiving medical evaluation for psychotropic medication (if applicable)
 - (c) Correspondence concerning the child's treatment to DCS Home County Family Services Worker, parents, and other treating providers
 - (d) Signed and dated notations of telephone calls concerning the child's treatment to DCS home county family services worker, parents, and other treating providers
 - (e) Documentation stating when and what information about the child is released to an individual or organization
 - (f) Copies of Notice of Action for any reduction, suspension, or termination of services
9. Other Provider information
 - (a) The other provider section of the treatment record shall contain copies of other providers' records that have been obtained to assist in the current treatment of the youth.

- (b) Release(s) of Information: Copies of release(s) of Information sent to other providers to get Information or provided to the provider by the Department of Children's Services to obtain information.
- 10. Documentation/Progress Notes must be in the child's file at a minimum documenting:
 - (a) Any incident or major episode in treatment
 - (b) Dates of family and sibling visitation and dates of contact
 - (c) Family services worker visitation
 - (d) Telephone contacts
 - (e) Child and Family Team Meetings
 - (f) At least weekly documentation of progress in foster homes
 - (g) Daily documentation of progress for all therapeutic foster care, medically fragile foster care, and all types of Level 2
 - (h) At each change of shift for residential treatment–Level 3 RTC and Level 4
 - (i) Providers must submit monthly summaries for all levels of care to the regional SAT coordinators and the TNCARE Advocates.
 - (j) All medical services
 - (k) All clinical services
 - (l) All collaborative meetings
- 11. A discharge summary of the services provided is entered into the individual client's case record or into the record within fifteen days and includes recommendations for any needed future services and the assignment of aftercare responsibility, when indicated in the service plan.

V. DISCHARGE AND DEAUTHORIZATION OF SERVICES

- 1. **Successful Program Completion**
 - a. Prior to successful completion of a program, the provider will prepare a discharge packet and forward it to DCS anticipating the child's planned departure from the agency. There must be a CFTM held prior to release.

- b. A TennCare Notice of Action will be issued to all involved adults and child prior to discharge for all Level II and above services.

2. Premature Discharge

- a. The provider may request a CFTM to remove a child from the program if the child has exhibited behaviors that would place him/her in the category of children who are not eligible for admission to the program. The provider shall be expected to exhaust and document all available means of service intervention prior to requesting such discharge. When the provider desires to discharge a child prior to successful completion of the program, the provider must request, in writing, that the department convene a CFTM. The agency cannot discharge a client from the program without a CFTM except in the unusual circumstances described below.
- b. The meeting will occur as soon as possible but no later than five (5) calendar days from the date of the request. The purpose of the meeting is for the provider, family, DCS family services worker, child (if appropriate), and other involved adults to reach consensus on a plan of action that would either allow the child to remain in the program or move to a more appropriate placement.
- c. The regional placement specialist must be notified of the proceedings. With the exception of very unique and unusual cases, DCS will not support removal of a child from the provider's program with the recommendation to place the child in a program of comparable level and treatment components.
- d. If there is agreement or if the decision of the appeals committee is that the child needs to move to another placement, DCS will arrange for and move the child within fifteen (15) days following the date of the consensus decision.
- e. In unusual circumstances when a child's behavior is so out of control as to make him/her a danger to self or others, the provider may immediately remove the child from the program only with the approval from the DCS family services worker.
- f. The provider should assist with this process in accordance with the plan of action that has been developed.

3. Repeat Runaway Situations

- a. In the case of runaway incidents, where the child appears to be a "repeat runaway risk," the provider, DCS home county family services worker, and resource placement specialist should develop a safety plan for the youth, in compliance with the revised DCS Appeals Process, and reach a mutual

decision on whether or not the child should remain in the program. Strong consideration should be given to the child's history of running away, safety concerns (for both the child and the community), need for additional supervision, and/or need for a more secure facility placement.

- b. Upon the return of a child from runaway, the provider will notify the department, who shall convene a CFTM to explore the dynamics leading to the runaway and shall notify law enforcement to cancel any alerts or reports.

4. Criminal Acts by Children While in Placement

- a. Charges may not be filed against a youth by a provider for behaviors that may be symptomatic of the youth's mental health diagnosis and/or treatment needs.
- b. In situations where there is disagreement as to whether or not the youth's behaviors are symptomatic of the mental health diagnosis or pose a substantial risk to the community, a clinical opinion should be sought to determine if charges should be filed.
- c. The provider should discuss the situation with the family services worker and resource placement specialist and a CFTM should determine whether continued placement is appropriate given the child's history, the incident itself, the risk to others in the program, the possible need for additional supervision, and/or a more secure placement, etc.
- d. If agreement cannot be reached and the provider maintains that the child should not remain in the program, the provider may appeal to the RRMG appeals committee, file a TennCare appeal, or request a review by the regional administrator and/or Central Office CPPP Division in the manner previously described above.
- e. The child will remain in the current placement until a decision is made. If the decision is to remove the child from the program, DCS will remove the child as soon as possible but within fifteen (15) days from the date of the decision.
- f. All procedures must be carried out in compliance with the revised DCS appeals process.

5. Deauthorization of Services

- a. Deauthorization may occur when it is determined that appropriate services to the child are not being provided and/or services are no longer needed from the provider.
- b. Deauthorization should be a consensual decision within the context of the

CFTM.

- c. If there is a clinical disagreement, a referral should be sent to one of the following, as agreed upon in the CFTM, for resolution:
 - 1. review by regional psychologist and/or nurse as specific situation indicates is most appropriate
 - 2. review by DCS director of Medical and Behavioral Services
 - 3. review/consultation through the Center for Excellence
- d. Any involved party has the right to file a TennCare Appeal.

W. REFERRALS TO POST-CUSTODY ADULT SERVICES FOR MENTALLY ILL OR MENTALLY RETARDED YOUTH

Provider agencies are expected to assist youth diagnosed with mental retardation who are aging out of custody in making referrals to the Division of Mental Retardation Services (DMRS) Adult Services. (Refer to DCS Policy 19.8)

<http://www.state.tn.us/youth/dcsguide/policies/chap19/19.8TransitioningYouthIntoTheDivisionofMentalRetarda.pdf>

1. Transition of Youth with Serious Emotional Disturbance to Adult Mental Health Services

- a. The provider agency must work to identify youth with severe mental health needs and assist with the move to post-custody services. The transition planning must start by age 16-1/2 years. Part of the process is helping the youth apply for SSI and/or exploring adult services offered by the Department of Mental Health through the community mental health centers.
- b. Ninety (90) days prior to the youth's custody release dates, a request for adult mental health case management shall be made through the local mental health agency. Sixty (60) days prior to the child becoming age 18, the adult mental health case manager is notified and included in the CFTM to assist in developing a plan for the youth's transition to adult mental health services, as well as other community services or outreach programs which might benefit and/or contribute to a level of stability and independence into adulthood.

(Refer to DCS Policy 19.7 Transitioning DCS Youth into Adult Behavioral Mental Health)

<http://www.state.tn.us/youth/dcsguide/policies/chap19/19.7TransitioningDCSYouthIntoAdultBehavioralMentalHealth.pdf>

2. Post-Custody Services for Youth with Mental Retardation

- a. Youth diagnosed with mental retardation must have a determination made as to whether or not the youth shall require post-custody services through the Department of Children's Services until transition to the Department of Mental Retardation Services occurs. These youth must be identified and a transition plan initiated by age 16-1/2. Part of the process is helping the youth apply for SSI. A concrete workable and realistic plan must be finalized and implemented by the time the youth is 17-1/2 years of age.
- b. For all youths aging out of custody and in the care of the provider agency, it is expected that the provider agency and the DCS family service worker will partner to identify permanency and/or a connection to a caring adult prior to the youth aging out of care to assist with the transition to self-sufficiency. It is further expected that the youth will be stable and not require intensive residential services at the time he/she transitions out of care.

X. MANDATED CLINICAL STANDARDS AND POLICIES

Agencies will use the DCS policies listed below to insure that legal and appropriate standards are followed in serving children/youth and their families.

INFORMED CONSENT FOR TREATMENT

Agencies will use:

DCS Policy 20.24 Informed Consent.

<http://www.tennessee.gov/youth/dcsguide/policies/chap20/20.24%20Informed%20Consent.pdf>

Adherence to this policy is mandatory. Provider agency staff can not give informed consent. If the child/youth can or will not give consent and the guardian can or will not give consent, the DCS Regional Health Nurse should be contacted for consent. Providers should help families and children/youth understand treatment and medication practices.

Please see **ATTACHMENT 10**, this document, for a summary sheet that can be copied and given to medical providers to explain what is needed.

MEDICATION STANDARDS AND PRACTICES

Agencies will use:

DCS Policy 20.15 Medication Administration-Storage and Disposal

<http://www.tennessee.gov/youth/dcsguide/policies/chap20/20.15%20Medication%20Administration-Storage%20and%20Disposal.pdf>

DCS Policy 20.18 Psychotropic Medication

<http://www.tennessee.gov/youth/dcsguide/policies/chap20/20.18%20Psychotropic%20Medication.pdf>

DCS Policy 20.21 Emergency and PRN Use of Psychotropic Medication

<http://www.tennessee.gov/youth/dcsguide/policies/chap20/20.21%20Emergency%20and%20PRN%20Use%20of%20Psychotropic%20Medication.pdf>

DCS Policy 20.59 Medication Error Guidelines

<http://www.state.tn.us/youth/dcsguide/policies/chap20/20.59%20Medication%20Error%20Guidelines.pdf>

Adherence to these policies is mandatory.

BEHAVIOR MANAGEMENT INTERVENTIONS

Agencies will use:

DCS Policy 19.1 Suicide-Self Harm Intervention

<http://www.tennessee.gov/youth/dcsguide/policies/chap19/19.1%20Suicide-Self%20Harm%20Intervention.pdf>

DCS Policy 25.10 Behavior Management

<http://www.tennessee.gov/youth/dcsguide/policies/chap25/25.10%20Behavior%20Management.pdf>

DCS Policy 27.1 Use of Mechanical Restraints (see also 31.15)

<http://www.tennessee.gov/youth/dcsguide/policies/chap27/27.1%20Use%20of%20Mechanical%20Restraint.pdf>

<http://www.tennessee.gov/youth/dcsguide/policies/chap31/31.15%20Transportation%20of%20Children-Youth%20by%20Regional%20and%20Field%20Services%20Employees.pdf>

DCS Policy 27.2 Seclusion

<http://www.tennessee.gov/youth/dcsguide/policies/chap27/27.2%20Use%20of%20Seclusion.pdf>

DCS Policy 27.3 Physical Restraint

<http://www.tennessee.gov/youth/dcsguide/policies/chap27/27.3%20Use%20of%20Physical%20Restraint.pdf>

Adherence to these policies is mandatory.

Follow the links to referenced policies and print in their entirety including any attachments.

SECTION TWO

FOSTER CARE/RESOURCE HOMES

I. General Requirements and Core Standards

A. Approval Requirements for Resource Parents

DCS Policy 16.4 Resource Home Approval

<http://www.tennessee.gov/youth/dcsguide/policies/chap16/16.4%20Resource%20Home%20Approval.pdf>

DCS Policy 16.3 Desired Characteristics of Resource Parents

<http://www.tennessee.gov/youth/dcsguide/policies/chap16/16.3%20Desired%20Characteristics%20of%20Resource%20Parents.pdf>

DCS Policy 16.8 Responsibilities of Approved Resource Parents

<http://www.tennessee.gov/youth/dcsguide/policies/chap16/16.8ResponsibilitiesofApprovedResourceParents.pdf>

DCS Policy 16.11 Shared Resource Homes

<http://www.tennessee.gov/youth/dcsguide/policies/chap16/16.11SharedResourceHomes.pdf>

DCS Policy 16.23 Resource Home Case Files

<http://www.state.tn.us/youth/dcsguide/policies/chap16/16.23%20Resource%20Home%20Case%20Files.pdf>

DCS Policy 16.27 Resource Parent Fourteen-Day Removal Notice and Right to Appeal

<http://www.tennessee.gov/youth/dcsguide/policies/chap16/16.27%20Resource%20Parent%20Fourteen-Day%20Removal%20Notice%20and%20Right%20to%20Appeal.pdf>

DCS Policy 16.29 Board Rates

<http://www.tennessee.gov/youth/dcsguide/policies/chap16/16.29%20Resource%20Home%20Board%20Rates.pdf>

1. Approval Process

Licensed private providers under contract with the State of Tennessee shall have a written policy outlining approval process for resource parents. Agencies may develop their own protocols in the provision of foster care services but the protocols must meet or exceed the DCS Foster Care Policy Standards.

2. Resource Home Eligibility Team (RHET) Protocol

Background

1. The Department of Children's Services (DCS) is subject to the rules and requirements set forth in 42 U.S.C. §672 and 45 CFR §1356.71. Known as Title IV-E of the Social Security Act (SSA), this statute sets forth standards for Federal payments for foster care and adoption assistance (sections 470-479a of the SSA). Failure to comply with these standards can result in the loss of federal funding for a limited period of time or for the duration of the foster care placement.
2. The Title IV-E Foster Care Eligibility Review Guide available on the Administration for Children and Families Web site (www.acf.hhs.gov), provides a consistent and uniform approach for Federal and State (as well as private provider staff) to use as resource in complying with requirements of the Title IV-E program. The guide contains policy and procedural guidance on adherence to all facets of Title IV-E compliance. It is intended to complement, not supplant, applicable statutory and regulatory provisions. In the event of conflict or inconsistency between the guide and the statute or regulations, the latter governs.
3. In response to these Federal requirements and to serve as a more effective steward of public funds, DCS has chosen to develop an internal infrastructure that will provide oversight for the eligibility of all provider resource home files.

ALL AGENCIES APPROVING RESOURCE HOMES MUST FOLLOW THIS PROTOCOL.

Attachment: #4 RHETT

B. Case File Organization

All resource home case files must be organized using the 16.23 section headings. However, it is not necessary to organize the files in the same order. For example, an agency may prefer not to have the Home Study and Reassessments section as the first section of the file, but the agency must ensure that the heading Home Study and Reassessments is used and that all the pertinent documentation listed in that section is included.

C. Working with DCS and Agency Staff

1. Prospective resource parent(s) shall have the ability to work with the agency as demonstrated by their ability to:
 - a. work constructively within the policy framework in developing plans and meeting the needs of the child and his/her family;

- b. accept and use professional consultation including mental health, medical, and educational assistance;
- c. provide information to the agency regarding the needs of a child in care;
- d. work in partnership with the agency and the Department of Children's Services to make key decisions related to the placement of children and termination of parental rights;
- e. maintain confidentiality regarding children and their birth parents;
- f. provide routine transportation for the foster children placed in their home; and
- g. participate in all health and mental health services for the child, and any other services being used to benefit a child in care.

D. Documentation of Approval for Resource Home

1. The approval letter must indicate the number and type of children for whom the home is approved.
2. The resource home approval must be signed and dated by the family services worker writing the resource home study, as well as two levels of supervision above the family services worker.
3. The date the resource home study is signed by the second level of supervision is the approval date. For those agencies without two levels of supervision, the agency director is the final approving authority; and the date s/he signs the home study is the approval date.

E. Family Composition

1. The resource home record must indicate the functional capacity for the resource home. Functional capacity is the actual number of children that the resource parent(s) can serve and is not necessarily the maximum number of children allowed in the home per DCS policy. Please note that the functional capacity cannot exceed the maximum number allowed.
2. Resource families shall not have more than a total of
 - a. three (3) foster children or
 - b. six (6) children, including birth children, foster children, and adoptive children residing full-time in the resource home.
 - c. There must be no more than three (3) children under the age of three years, including birth children, foster children, and adoptive children.
 - d. Exceptions can be made for sibling groups.
3. **Brian A. Requirement Note:** An agency under contract with DCS is held accountable for critical incidents, disruptions, number of moves, and successful discharges for all children in their program. This accountability necessitates decision making by the agency that should avoid negative outcomes. Therefore, the number of placements of children in a resource home should be a careful

undertaking of the agency.

4. The resource home shall not provide placements for more than one agency at a time without a written agreement delineating the responsibilities of all parties involved and approved by the agency executive directors and the DCS contract authority.

F. Health Requirements

DCS Policy 16.4

G. Income and Employment

DCS Policy 16.4

H. Background and Other Records Checks

DCS Policy 16.4

I. Physical Facilities Related to Approval Process

DCS Policy 16.4

J. Expedited Placements

Providers do not use expedited placements.

K. Modification or Waiver of Requirements for Approval of Resource Home

DCS Policy 16.4

L. Resource Home Reassessment Checklist

1. A current resource home placement checklist shall be used and provided to the resource parent at the time of placement of a child in a resource home.
2. The resource parent shall be provided a completed copy of the checklist with all information that is available to the department/contract agency no later than at the time the foster care placement contract is signed,
3. The form must be signed and dated by the agency representative providing information to the resource parent and the accepting resource parent. A copy of the form must be provided to the resource parent.

M. Resource Home Reassessment

1. Licensed private providers under contract with the State of Tennessee shall have a written policy addressing annual reassessment of resource homes which contains the information referenced in DCS Policy.

N. Resource Parent's Rights

1. See **Attachment 5 Foster Parent's Bill of Rights**
2. Grievance Procedures

Agencies must develop a process that mirrors the intent of the grievance procedures outlined in

DCS Policy 16.27 Resource Parents' Fourteen –day Removal Notice and Right to Appeal.

3. Resource parents wishing to provide higher level of care, including Level II, therapeutic care, care for medically fragile children or care for juvenile justice youth, should make application to a private provider, unless an arrangement can be made in compliance with **DCS Policy 16.11**, Shared Resource Homes.

II. Standard Foster Care Services

A. Scope of Services

Foster Care services are for children and youth, who need safe, nurturing care and guidance in a private home outside their family. Their needs can be met through services delivered by trained resource parents. These resource parents are to be supervised and supported by agency staff, working together to meet the goal of permanency based on the best interest of the child. The families of children in foster care are offered support services to facilitate reunification whenever appropriate. If reunification is not an option other considerations include kinship care, adoption or guardianship.

B. Admission/Clinical Criteria

Child and Adolescents Needs and Strengths (CANS) must be suggestive of Level I Services. The final determination must be made through the Child and Family Team Meeting (CFTM).

Children accepted for the service are determined to be unable to receive the parental care they need in their own home. These children appear to be capable of forming family attachments and able to participate in family and community activities without posing a serious danger to themselves or others. Children who meet criteria for this level of care cannot be excluded from admission based on their adjudication when their risk is moderate to low or they have successfully completed a treatment program.

C. Personnel Ratio

1. Provider Caseworkers' caseload shall not exceed fifteen (15) children.
2. Resource parents have no more than three of their own minor children in the home and no more than three foster children are placed in a resource home at one time, unless a sibling group is to be placed together or other justification for an exception.

D. Resource Parent Training DCS Policy 16.4 and 16.8

See Attachment 7 Resource Parent Training Guide

E. Individualized Treatment Plan

1. Within thirty (30) days of placement, a written service or treatment plan will be developed with inclusion of all stakeholders in accordance with child and family team meeting policy. This plan must support the permanency goal(s) and should provide details specific to the agency's role in supporting the child in achieving permanency. The treatment plan must include child and family visitation as detailed in the child's permanency plan. (See Section One, Core Standards.)

F. Service Overview

1. The agency shall meet the standards set forth in Section One, Core Standards
2. The agency obtains, coordinates, and supervises, with the ongoing participation of the resource parents, any needed medical, behavioral, educational, recreational, remedial, or other specialized services and resources as described in the treatment plan.
3. The agency provides case management, consultation and coordination of services to meet the identified needs of the child, family, and resource family.

G. Service to the Child/Youth

1. Child placement will be prioritized as follows (unless it is clearly documented in the client's record why this is not in the child's best interest):
 - a. with siblings, (where there is a family group);
 - b. with kin; or
 - c. with a resource family who resides within reasonable proximity to the child's family and home community in order for family and community ties to be maintained; and
 - d. in the most appropriate setting or environment consistent with the child's needs.
2. Each child served is
 - a. provided safe, stable care in a nurturing environment to facilitate permanency as well as to promote their development and growth;
 - b. provided guidance, structure, protection, while offering participation/inclusion in as many positive experiences as possible;
 - c. prepared for placement with a specific resource family to include help with adjustment;
 - d. encouraged to maintain contact with their family or "circle of support" and provided with support in making such arrangements, unless specifically contraindicated because of the child's safety;
 - e. provided with information about family activities and progress toward the goal of permanency;
 - f. provided with assistance in maintaining the relationship with siblings through visits and shared activities;
 - g. prepared for return home or for placement in a stable, nurturing, permanent environment; and
 - h. provided Independent Living services in accordance to *DCS Policy 16.52*
3. Children are provided with developmentally appropriate activities and supportive services designed to enable them to prepare to lead self sufficient adult lives, in accordance with their treatment plan.
4. Resource parents are expected to participate fully in therapeutic and medical services provided for the child/youth as determined by the provider agency. These activities extend to educational services (e.g., PTA meetings, parent-teacher conferences, etc.) as

well as the provision of opportunities for the child to participate in appropriate extra-curricular activities (sports, dance, band, Scouts, etc.) in order to enhance his/her strengths and address needs.

H. Service to the Permanency Family

1. While it is not reasonable to expect the direct application of all services by contracting agencies, it is expected that agencies assist in the identification and coordination of supportive services to the child's permanency family; enabling them to plan for the child's reunification or concurrent permanency goal. Such supports may include but are not limited to:
 - a. child care;
 - b. homemaker and home health aide services;
 - c. parent education
 - d. respite care;
 - e. transportation services;
 - f. vocational and educational assistance;
 - g. health and mental health care;
 - h. substance use treatment services;
 - i. domestic violence services;
 - j. housing referral and assistance
2. Unless the child's safety would be compromised, services are provided to help the child's family maintain and enhance parental functioning, parental care, and parental ties. Documentation must be present in the child's record of reasonable efforts toward reunification.
3. The agency worker must document in the client record meeting with the child's parent(s) without the child at least one time per month. During the meetings the worker should:
 - a. evaluate safety and well-being;
 - b. monitor service delivery; and
 - c. support the achievement of permanency and other service plan goals
4. Case records contain information regarding the agency's efforts to promote reunification opportunities. Documentation will record, in detail, the agency's attempts to assist the family in
 - a. making a plan for their child,
 - b. visiting and maintaining contact with their child,
 - c. overcoming barriers to their involvement in the child's care, contact or visitation, and
 - d. utilizing the resources the agency offers to prepare the family for reunification.

I. Service to the Resource Family

1. Resource parents assume an integral role in providing care and services for children placed in their homes.
2. Supports to Resource families include but are not limited to
 - board rates to meet or exceed the basic board rates outlined in ***DCS Policy 16.29***;
 - transportation assistance;
 - training (individual and group)/ongoing in-service as well as any required/requested specialized training to meet the needs of each child placed in the home;
 - case management consultation and coordination;
 - respite services to meet or exceed Department of Children's Services Policy 16.13; and
 - counseling/crisis intervention.
3. Agency will support Resource family in coordinating services to children, including, but not limited to:
 - school liaison services;
 - child/family visitation coordination;
 - social services referrals, consultation, and coordination; and
 - medical/dental appointments for the child.
4. The agency will meet all its obligations under the Resource Parent Bill of Rights including making a copy available to them and providing training on the document.
5. **The agency will have an appeals process for its families that mirrors that of the department.**
6. The agency will assist resource parents in all forms of child advocacy including advocacy related to school and medical and behavioral health.
7. The agency Case Worker has a face-to face-interview with the Resource parents within the first week of placement and at least once every four weeks thereafter. The encounters are recorded through the provider Face-to-Face Web Application.
8. The agency has a policy addressing payment to Resource parents.

J. Education

1. Typically, children in foster care attend public school.
2. The agency has an educational liaison and ensures all children receive educational services in the most appropriate setting or environment and have services to promote academic success.

K. Monitoring Progress/Utilization Review

1. The agency must record all face-to-face visits through TNKids Financials.
2. The agency must participate in any other reviews deemed necessary by DCS or the courts.
3. The agency must participate fully with Program Accountability and Review monitoring.
4. The agency will respond and provide immediately required documentation as requested by TennCare Consumer Advocate (TCCA) or Tennessee Alliance for Legal Services (TALS)
5. The agency will meet the standards outlined in Section One.

L. Discharge Criteria

1. The Child and Family Team will review the permanency plan at scheduled intervals or when needed. The CFT will determine when goals for permanency have been met and will recommend discharge with input from all members of the child/youth's team.
2. Discharge must include a plan that includes but is not limited to, consideration of the child's:
 - ☐ Educational needs,
 - ☐ Additional support for stability for the child and family,
 - ☐ A plan for accessing community support,
 - ☐ An inventory of the child's personal items to insure availability at time of discharge,
 - ☐ Medical and behavioral needs, and
 - ☐ Any additional supports that the child and family may need to maintain stability.

III. Medically Fragile Foster Care Services

A. Scope of Services

1. The Medically Fragile Foster Care program provides recruitment, training, and support services to resource parents to meet the needs of children/youth who are appropriate for family-based care but require a higher level of medical support, intervention, and case coordination.
2. Resource parents are specially trained to care for children/youth with extreme medical needs that cannot be met in their family homes. Some of these resource parents are also trained to manage behavioral and emotional disorders in addition to the training required to meet the medical needs of this population.
3. Due to the needs of these children/youth, agencies approved to provide medically fragile foster care services must be willing and able to accept emergency and after-hours referrals.
4. The goals/discharge criteria for children/youth in Medically Fragile Foster Care are permanency through reunification, kinship care, adoption, or guardianship.

B. Admission/Clinical Criteria

1. A child/youth requiring medically fragile foster care has significant medically oriented care needs related to a serious illness or condition (documented by a licensed health care provider) that may become unstable and change abruptly, resulting in a life-threatening situation.
2. The child's/youth's care needs may be related to a chronic and/or progressive illness or a more acute, time-limited condition.
3. The child/youth may have a severe disability that requires the routine use of medical devices or assistive technology to compensate for the loss of usefulness of a body function needed to participate in activities of daily living.
4. The conditions/care needs of child/youth requiring medically fragile foster care are evaluated on a case-by-case basis by the DCS Regional Nurse.
5. Children/youth who are determined to need medically fragile foster care and who also have behavioral and/or emotional conditions may be considered for a higher level of care within the agency's resource home network if the decision is supported by the CTFM.

C. Personnel Ratio

1. The agency will meet all criteria outlined in Core Standards for Foster Care.
2. Ratio of case work staff to cases does not exceed 1:10.
3. Resource homes with only one adult in the home may not care for more than one child/youth requiring medically fragile foster care and may not have more than two

additional children/youth in the home.

5. Resource homes with two adults in the home shall not care for more than two children/youth requiring medically fragile foster care and may not have more than two additional children/youth in addition in the home.
6. Resource homes must be within 45 minutes of a local medical facility and emergency room.
7. Any exceptions to these requirements will be addressed through the Placement Exception Request process.

D. Resource Parent Training DCS Policy 16.4

See Attachment 7 Resource Parent Training Guide

Pre-service: In addition to what is required for Standard Foster Care pre-service, all newly approved resource parents for medically fragile services are required to complete an additional fifteen (15) hours of medically-oriented specialized training prior to caring for children and necessary to competently care for the greater needs of the foster children/youth at this level. Possible training topics for the additional 15 hours are as follows:

- Growth and development
- Nutrition
- Medical disabilities
- Orientation to Assistive Technology
- Seizure Management
- Caring for Drug-Exposed Children

In addition to the above requirements, resource parents shall receive specialized training on the special medical needs of each child/youth to be placed in their home.

In-service:

- ☐ The agency will meet all criteria as outlined in Standard Foster Care for first year in-service (15 hours to be completed within the first year after approval date).
- ☐ After the first year, each resource parent providing medically fragile foster care services must complete fifteen (15) hours of in-service training each year using the anniversary date of approval.
- ☐ For any exceptions or variations, please submit to CPPP for approval.

E. Individualized Treatment Plans

The agency will meet all criteria outlined in Standard Foster Care.

F. Service Overview

1. The agency shall meet the standards set forth in Standard Foster Care in addition to meeting the needs of the special population of children/ youth needing medically fragile foster care services.
2. Foster family care is provided for and on behalf o the child/youth under a plan that

includes services for the child's/youth's parents and supervision of and support services for the resource parents.

G. Service to the Child/Youth

The agency will meet all criteria outlined in Standard Foster Care.

1. Children are provided with developmentally appropriate activities and supportive services designed to enable them to prepare to lead self-sufficient adult lives in accordance with their treatment plan.
2. For instances in which a hospital requires a sitter twenty-four (24) hours per day, seven (7) days per week; twelve (12) hours of sitter services shall be provided by the resource parent/private provider agency. The additional twelve (12) hours shall be provided through the delegated authority and funded by DCS.

H. Service to the Permanency Family

The agency will meet all criteria outlined in Standard Foster Care.

I. Service to the Resource Family

The agency will meet all criteria outlined in Standard Foster Care.

J. Education

1. These children will typically attend public school. Requirements are provided through local LEA as determined by the school system.
2. The agency will meet all criteria outlined in Core Standards.

K. Staff Professional Development

1. The agency will meet all criteria outlined in Section One-Core Standards, Chapter II.

L. Monitoring Progress/Utilization Review

1. The agency provides a monthly summary of child/youth's progress and current status. The monthly summary should be sent to the child's/youth's Regional SAT Coordinator and TENNCARE advocate.
2. The DCS Regional Nurse will review each child/youth placed in the medically fragile foster care program on a quarterly basis. This review may include face-to-face visits and /or other means of communication with the child/youth and resource parent(s). This visit will be in conjunction with the Agency case manager and DCS Home County FSW when possible.
3. The DCS Regional Nurse will make a recommendation for a child's/youth/s continued placement in the medically fragile program based on monthly summaries from the agency, medical reports and progress updates from the child's/youth's medical

provider(s), and observations during the quarterly visits/communication with the child/youth and resource parent(s).

4. The DCS Regional Nurse will send written notification of the medically fragile foster care recommendation to the following:
 - Agency Case Manager, Agency Director or Supervisor
 - DCS Home County FSW
 - DCS Team Leader
 - DCS Team Coordinator
 - DCS Placement Services Division
 - DCS Regional Administrator

Note: *The above is only a list of those persons who will receive the written recommendation from the DCS Regional Nurse. It is not meant to be a list of persons invited to the CFTM. IF a CFTM is indicated, the DCS Home County FSW will send notifications to any and all interested parties.*

M. Discharge Criteria

1. If the DCS Regional Nurse determines the child/youth no longer needs medically fragile foster care, the recommendation will include a request for a CFTM. The DCS Home County FSW should convene a CFTM as soon as possible but no later than seven (7) days from the date of the recommendation notice from the DCS Regional Nurse.
2. The written recommendation from the DCS Regional Nurse that the child/youth no longer needs medically fragile foster care is simply a trigger for a CFTM. It does not change the placement or the rate.
3. If a child/youth is no longer recommended for the medically fragile foster care program, a decision will be made at the CFTM whether the child/youth will continue placement with the current resource parent(s) and transition to a lower level of care or if the child/youth will be moved to a new placement. If the child/youth is to remain with the current resource parent(s), the rate change will take place no later than 14 days after the date of the CFTM.
4. If the child/youth is moved to a new placement, the rate change will take effect on the date of the placement change.

IV. Therapeutic Foster Care Services

A. Scope of Services

1. The program is specifically designed to accommodate the needs of emotionally disturbed and behaviorally disordered children who are at risk for failure or have failed in regular resource homes, have been unable to live with their own families, or who are going through a transitional period from group care as part of the process of return to family and community.
2. Therapeutic foster care services include recruitment, training, and support services to resource parents trained to meet the needs of children who are appropriate for family-based care but require behavioral intervention, case coordination and /or counseling services. Therapeutic foster care parents may require more frequent respite support services and training in behavioral intervention.
3. Agencies providing therapeutic foster care services will follow all policies, criteria, and guidelines contained in the Standard Foster Care section as well as the additional guidelines as follows and indicated in the Therapeutic Foster Care Section.
4. The goal/discharge criteria for children in therapeutic foster care is permanency through reunification, kinship care, adoption or guardianship.

B. Admission/ Clinical Criteria

1. Children who are appropriate for therapeutic foster care can include but are not limited to
 - ☐ those who have successfully completed higher levels of treatment, including sex offender treatment programs ,
 - ☐ those who do not pose an ongoing risk to themselves or the community,
 - ☐ or for those who have been diagnosed with a psychotic disorder that is adequately managed through medication.
2. Children's needs are identified through a Child and Family Team Meeting as to the appropriateness for therapeutic foster care, with age-appropriate youth included in the decision-making process.
3. The agency may not reject children who have been determined to meet the scope of services.

C. Personnel Ratio

1. The ratio of children to caseworker does not exceed 10:1.
2. Resource families shall have no more than two (2) therapeutic foster children in the resource home. Exceptions can be made for sibling groups.

D. Resource Parent Training See DCS Policy 16.4 See Attachment 7 Resource Parent Training Guide

1. Pre-service: In addition to what is required for standard foster care, newly approved therapeutic foster care resource parents will complete 15 hours of specialized pre-service training using a therapeutic curriculum prior to children being placed in the home.
2. In-service: The agency will meet all criteria as outlined in Standard Foster Care.

E. Individualized Treatment Plans

The agency will meet all criteria as outlined in Standard Foster Care.

F. Service Overview

The agency will meet all criteria as outlined in Standard Foster Care.

G. Service to the Child/Youth

Each child served

1. will receive a mental health assessment to determine need for on-going treatment,
2. is prepared for placement with a specific resource family to include help with adjustment
3. is encouraged to maintain contact with their family or “circle of support” and provided with support in making such arrangements, unless specifically contraindicated because of the child’s safety,
4. is provided with information about family activities and progress toward the goal of permanency,
5. is provided with assistance in maintaining the relationship with siblings through visits and shared activities,
6. is prepared for return home or for placement in a stable , nurturing, permanent environment, and
7. is provided independent living services in accordance with DCS policy on interdependent living (see VI, this Section).

H. Service to the Permanency Family

1. The agency will meet all criteria as outlined in Standard Foster Care.
2. The agency will support and mentor relationships between the child’s family and resource family regarding therapeutic issues in accordance with the permanency plan. Contacts must be documented.

I. Service to the Resource Family

The agency will meet all criteria as outlined in Standard Foster Care.

J. Education

1. Typically, children in therapeutic foster care will attend public school.
2. Students may require additional in-school supports to maintain positive school behavior.
3. The agency will meet all criteria as outlined in Standard Foster Care.

K. Staff Professional Development

The agency will meet all criteria as outlined in Section One-Core Standards,

L. Monitoring Progress/Utilization Review

The agency will meet all criteria as outlined in Standard Foster Care.

M. Discharge Criteria

The agency will meet all criteria as outlined in Standard Foster Care through the use of the Child and Family Team Meeting.

VI. Juvenile Justice Foster Care Services

A. Scope of Services

The agency will meet all criteria as outlined in Standard Foster Care.

B. Admission/Clinical Criteria

The agency will meet all criteria as outlined in Standard Foster Care.

C. Personnel Ratio

The agency will meet all criteria as outlined in Standard Foster Care.

D. Resource Parent Training

The agency will meet all criteria as outlined in Standard Foster Care with the addition of **9 hours of Juvenile Justice Training** before a resource home can care for a Juvenile Justice child/youth.

E. Individualized Treatment Plan

The agency will meet all criteria as outlined in Standard Foster Care.

F. Service Overview

The agency will meet all criteria as outlined in Standard Foster Care.

G. Service to the Child/Youth

The agency will meet all criteria as outlined in Standard Foster Care.

The agency will refer to **DCS Policy 12.5 Passes for Youth Adjudicated**

<http://www.tennessee.gov/youth/dcsguide/policies/chap12/12.5%20Passes%20For%20Youth%20Adjudicated%20Delinquent.pdf> in order to work cooperatively with the

DCS Family Service Worker.

H. Service to the Permanency Family

The agency will meet all criteria as outlined in Standard Foster Care.

I. Service to the Resource Family

The agency will meet all criteria as outlined in Standard Foster Care.

J. Education of the Youth

The agency will meet all criteria as outlined in Standard Foster Care.

K. Staff Professional Development

The agency will follow all criteria as outlined in Section One-Core Standards, Chapter II.

L. Documentation/Utilization Review

The agency will meet all criteria as outlined in Standard Foster Care

M. Discharge

- ☐ The agency will meet all criteria as outlined in Standard Foster Care.

The agency will refer to **DCS Policy 12.1 Return to Home Placement: Youth Adjudicated Delinquent .**

<http://www.tennessee.gov/youth/dcsguide/policies/chap12/12.1%20Return%20To%20Home%20Placement-Youth%20Adjudicated%20Delinquent.pdf>

V. Interdependent Living Services

DCS Policy 16.51, Interdependent Living Plan

<http://www.tennessee.gov/youth/dcsguide/policies/chap16/16.51%20Interdependent%20Living%20Plan.pdf>

DCS Policy 16.52, Eligibility for Interdependent Living and Voluntary Post-Custody Services

<http://www.tennessee.gov/youth/dcsguide/policies/chap16/16.52%20Eligibility%20for%20Interdependent%20Living%20and%20Voluntary%20Post%20Custody%20Services.pdf>

DCS Policy 16.53, Identifying and Accessing Interdependent Living Services

<http://www.tennessee.gov/youth/dcsguide/policies/chap16/16.53%20Identifying%20and%20Accessing%20Interdependent%20Living%20Services.pdf>

DCS Policy 16.54, Provision of Voluntary Post-Custody Custody Services to Young Adults

<http://www.tennessee.gov/youth/dcsguide/policies/chap16/16.54%20Provision%20of%20Voluntary%20Post%20Custody%20Services%20to%20Young%20Adults.pdf>

DCS Policy 16.55 Post-Secondary Scholarships: Educational and Training Vouchers and State Funded Scholarship

<http://www.tennessee.gov/youth/dcsguide/policies/chap16/16.55%20Post%20Secondary%20Scholarships%20and%20ETVs.pdf>

DCS 16.56 Living Allowance

<http://www.tennessee.gov/youth/dcsguide/policies/chap16/16.56%20Interdependent%20Living%20%20Direct%20Payment%20Allowance.pdf>

A. Scope of Services

The program is specifically designed to help youth and young adults develop supportive relationships with adults (facilitate permanency), acquire an array of life skills, encourage the recognition and utilization of community resources, and increase self-esteem and self-empowerment. Provision of these services should must promote a Chafee Foster Care Independent Living goal, to include educational progress, employment, maintenance of physical and mental health care, housing opportunities, the formation of supportive adult relationships, knowledge of, and access to, community resources, the acquisition of skills to increase financial viability , and daily life skills.

In order to access services through DCS, please contact the independent living specialist in your region to begin the assessment process. It is critical that providers/family services workers do not enroll students in postsecondary placement

without the knowledge and or approval of the independent living personnel in their region. Specific documentation is required in order to be compliant with federal/state policies, receive reimbursement, and achieve quality care for young adults.

B. Admission/Clinical Criteria

1. DCS shall provide Interdependent Living Services to youth in state custody 14 to 18 years of age. Youth adjudicated delinquent and in state custody may receive specified Interdependent Living services up to their 19th birthday, commensurate with their placement status.
2. DCS shall provide Voluntary Post-Custody Services to eligible young adults exiting custody at age 18, or up to their 19th birthday, and requesting to receive such services from DCS. Voluntary Post-Custody Services may be provided up to the 21st birthday, and may be extended up to the 23rd birthday based on the young adult's status and continued eligibility.
3. Youth 15 years of age or older who exit custody to adoption or subsidized permanent guardianship may be eligible for Educational and Training Vouchers (ETV).
4. Youth 16 years of age or older who exit custody to reunification may be eligible for Educational and Training Vouchers(ETV).
5. Young adults, in conjunction with their Child and Family Teams, shall determine the scope and appropriateness of service needs within the overall margins of eligibility.

C. Personnel (ratio of child to staff): NA

D. Resource Parent Training: NA

E . Individualized Treatment Plans

Every youth in out-of-home care fourteen (14) years of age or older shall have an Interdependent Living Plan included as part of the Permanency Plan to help prepare youth for a successful transition to adulthood. As a component of the Permanency Plan, the ILP shall be developed concurrently with the Permanency Plan within the context of a Child and Family Team Meeting. Youth age fourteen (14) or older must complete the necessary life skill assessments, in advance of the plan development. Any youth in out-of-home care who is age seventeen(17) years and six (6) months or older shall have goals included in the Interdependent Living Plan that address transition to adulthood from state custody. Young adults receiving DCS Voluntary Post-Custody Services shall have an Interdependent Living Plan developed and updated annually.

F. Service Overview

The agency shall meet the standards set forth in DCS Practice Model 8-100,8-102,8-105, 8-106, 8-104, 8-107, PA-CM3.04. PA-CM4.01, PA-CM 5.05

G. Service to the Child/Youth

All youth meeting eligibility requirements for Interdependent Living Services must receive Life Skill Instruction as a component of Interdependent Living Services. The scope of instruction should be consistent with the life skill assessment results and recommendations, and provided in accordance with the youth or young adult's development capabilities. All eligible youth and young adults shall receive instruction in the following areas as a minimum requirement:

- Instruction in the acquisition of safe and affordable housing, and household management;
- Budgeting;
- Building Credit;
- Consumer Competence;
- Nutrition and food preparation;
- Stress management and coping;
- Time Management;
- Interpersonal relationships and communication;
- Problem solving and decision making;
- Hygiene, self-care and personal safety;
- Exercising legal rights and responsibilities, such as voting, legal representation, self-advocacy, youth's rights, and youth boards.
- Education on housing issues, to include locating safe and affordable housing options, tenants rights and responsibilities, housing assistance;
- Instruction on education issues, to include assistance with developing an appropriate education plan, completing secondary education and accessing resources for post-secondary educational institutions or vocational programs; and
- Instruction on obtaining and maintaining employment to include the development of good work habits and skills, self-confidence and presentation skills, resume writing, completion of job application, job seeking skills, and the use of local employment assistance and placement programs.

- Interdependent Living Wraparound funding as a resource to support the provisions of Interdependent Living for eligible youth and young adults. These resources are administered as a flexible funding resource to support goals as established in the Interdependent Living Plan.

H. Service to the Permanency Family (NA)

I. Service to the Resource Family (NA)

The agency will meet all criteria outlined in Foster Care.

J. Education

1. Youth will receive instruction on education issues that will include assistance in developing an appropriate education plan, completing secondary application and accessing resources for post secondary educational institutions or vocational programs.
2. DCS will provide assistance through Chaffee Educational and Training Vouchers (ETV's) toward the cost of attendance, as defined by the Higher Education Act of 1965 and provide assistance through the State Funded Scholarship to eligible youth and young adults.

K. Staff Professional Development

The agency will meet all criteria outlined in Core Standards

L. Documentation/Utilization Review

The Office of Interdependent Living will monitor and promote the ongoing connections for youth and young adults in state care by facilitating a network of relevant supports with caring adults and tangible resources, training and involving professionals, caretakers and advocates regarding these supports and services, and empowering youth and young adults to utilize such means to become confident and productive individuals.

M. Discharge Criteria

The Child and Family Team will review goals and progress at recommended intervals. The Team, with the involvement of the youth, will make recommendations for discontinuing services.

SECTION THREE

RESIDENTIAL TREATMENT

I. Level II— CORE STANDARDS FOR RESIDENTIAL TREATMENT

A. SCOPE OF SERVICES

Level II Residential Treatment is designed to meet the needs of children who are unable to live at home or in a Resource Family and require temporary care in a group or residential setting. The residential treatment program provides structure, counseling, behavioral intervention and other services identified in a child's permanency plan for children with moderate clinical needs. Children in this program type attend public school in the community.

Goals/discharge criteria for Children in Level II Residential Treatment:
Permanency through reunification, kinship care, adoption, or guardianship.

B. ADMISSION/CLINICAL CRITERIA

1. The service is available to children—regardless of adjudication type—whose relationship with their families or whose family situation, level of development, and social or emotional problems are such that services in a family setting would not meet the child's treatment needs due to supervision, intervention, and/or structure needs.
2. Programs are designed for youth in need of twenty-four hour care and integrated planning addressing behavioral, emotional, or family problems and the need for progressive reintegration into family and community living. Children in Level II Residential Treatment remain involved in community based schools and participate in community based recreational activities with appropriate supervision.
3. Children may have a history of truancy but are able to attend public school with liaison and support services provided by the agency.
4. Children may have a history of impulsive behaviors, alcohol and/or drug misuse, aggression, and moderate mental health treatment and intervention needs. Children may have patterns of runaway episodes, have difficulty maintaining self-control, display poor social skills, and/or have difficulty accepting authority.
5. Children in this level of care have behaviors that can be treated in a non-secure setting, with adult supervision and intervention.
6. Children may have completed higher levels or intensity of care and

determined appropriate for a move towards permanency.

7. Children in this level of care do not meet the criteria for higher levels of care.
8. Children in this level of care may require outpatient therapy, medication, and medication management which will be coordinated by the agency and integrated into treatment planning.
9. Children with developmental delays are reviewed on a case-by-case basis to determine if the child could be appropriately served by the agency. A diagnosis of mental retardation is not used as a basis to refuse admission to a child when the child's behavioral issues fall within the Level II guidelines.
10. The agency may not reject children who fall within the scope of services.
11. Children who are ineligible for this level of care are those who have need of acute psychiatric hospitalization and/or require incarceration for major acts of violence or aggression within the past six (6) months. Those who pose a significant risk to the community are not appropriate for this level of care.

C. PERSONNEL RATIO

1. Adequate care and supervision is provided at all times to assure that children are safe and that their needs are met, in accord with their developmental level, age, and emotional or behavioral problems, and include
 - a. at least one on duty child care worker providing continuous supervision for each living group of eight children or youth;
 - b. higher adult/child ratios during periods of greater activity;
 - c. availability of additional or back up child care personnel for emergency situations or to meet special needs presented by the children in care; and
 - d. overnight awake staff at 1:8 ratio.
2. No more than five (5) experienced providers of case coordination or casework service report to one (1) supervisor.
3. The case loads for personnel providing case coordination or casework services do not exceed fifteen (15) residents, and may be adjusted according to current case responsibilities.
4. No more than seven (7) experienced direct care staff members report to one supervisor and the ratio is reduced to one to five when the workers are inexperienced.
5. The agency has the services of a licensed physician available on at least

an on-call basis to provide and/or supervise medical care.

6. Summary: In Residential Programs, the minimum staff to child ratio is:
 - a. Residential Level 2—1.8 during the day and 1.8 overnight awake staff
 - b. Residential Level 3—1.5 during the day and 1.8 overnight awake staff
 - c. Residential Level 4—Provide a direct-care staffing level of at least 2 direct-care staff members on duty/on site per ward per shift with at least one (1) nurse per building per shift. Supervision by a Registered Nurse must be provided at the facility on a 24-hour per day basis.

D. INDIVIDUALIZED TREATMENT PLANS

The agency will meet the standards outlined in Chapter One, Section III.U.

E. SERVICE OVERVIEW

1. The agency shall meet the standards set forth in Chapter One, Core Standards.
2. The service provides group living experiences and a program of specialized services for each child accepted for care.

F. SERVICE COMPONENTS PROVIDED WITHIN THE PER DIEM

1. Planning for stability and permanence in the care and provision of services to each child includes:
 - a. engagement of the child's parents in the placement and planning process;
 - b. ongoing efforts to obtain parental participation in services;
 - c. assistance to the child's parents in resolving problems that necessitated the child's removal;
 - d. retention of the maximum feasible family involvement in the decision-making and maintenance of contact between the family and child (unless clearly contraindicated by the Child and Family Team); and
 - e. assistance with recruitment of an adoptive or a long-term resource family, if indicated by the child's permanency plan.
2. Depending on the needs of the children in care, the services of qualified professionals in various mental health disciplines, consultants and specialists in dentistry, medicine, nursing, education, speech, occupational and physical therapy, recreation, dietetics, and religion are

available among the agency's personnel or through cooperative arrangements, and are integrated with the core services of the agency to provide a comprehensive program. Basic services include but are not limited to

- a. Educational liaison;
- b. Coordination of individual, group and/or family therapy by an appropriately licensed or credentialed provider;
- c. Individual, group and/or family counseling provided by person with a bachelor's degree and at least one year of experience supervised by master level personnel;
- d. Recreational programming;
- e. Structured behavioral assessment, management and intervention system;
- f. Three (3) hours daily of documented, structured individual or group treatment activities and/or process groups;
- g. Individualized intervention services identified as needed to meet the child's treatment goals;
- h. Alcohol and drug intervention;
- i. Independent living training and skills building;
- j. Coordination of outpatient alcohol and drug treatment;
- k. Case management and coordination.

G. EDUCATION

1. There is a presumption that children in Level II care will attend public school. Educational services must be met through the most appropriate setting to meet the educational and treatment needs of the child. This includes both general and special education programs. Programs must operate or subcontract a self-contained educational services, if there is an exception approved for the child to attend a self-contained educational program through a Child and Family Team meeting, as outlined in Educational services policy. Providers of on-site educational programs must be approved as providers of this type of service by the Department of Children's Services. Any child receiving educational services in a self-contained (in-house) school setting must be approved for these services through a Child and Family Team review, as outlined in Department of Children's Services educational policy.
2. Agencies with group homes or residential treatment centers will appoint a local staff member to act as "school liaison." The agency school liaison will develop a collaborative relationship with the public school system to assist children/youth in maintaining positive and successful school experiences.

The school liaison must be available during the school day to respond to public school inquiries.

3. Former school records are obtained promptly upon admission and up to date records are provided to the new school when the child is referred elsewhere.
4. Personnel from the residential center facilitate school transfers and provide consultation as needed to the professionals in off-campus educational settings.
5. Agency provides tutoring, academic enrichment or other services needed for the child to successfully achieve educational goals.

H. MONITORING PROGRESS

1. Level II Residential Programs examine the need for and appropriateness of service for clients through a child and family team meeting, at least quarterly or as determined by the team, reviewing:
 - a. continued out-of-home care;
 - b. efforts for family reunification; and
 - c. the adequacy of efforts to preserve and continue the parent/child relationship when possible and in the child's interest.
2. The agency must submit a Monthly Progress Report to the DCS Family Services Worker and Resource Management Unit, Involved Adult, if any, and the Advocacy Contractor.
3. The agency must participate in any other reviews deemed necessary by DCS or the courts.
4. The agency must participate fully with Program Accountability and Review monitoring.
5. The agency will respond and provide immediately required documentation as requested by TennCare Consumer Advocate (TCCA) or Tennessee Alliance for Legal Services (TALS).

I. UTILIZATION REVIEW

The agency will meet the standards outlined in Section One, Section I. F.

J. DISCHARGE CRITERIA

Children/youth will be discharged in compliance with CFTM protocol.

II. Residential Treatment Level III

A. SCOPE OF SERVICES

Level III Residential Treatment provides a therapeutic treatment program in a non-hospital, 24-hour-a-day residential facility for children and youth with severe emotional and/or psychological treatment needs. Through an individualized treatment plan, the agency provides intensive mental health treatment, including psychiatric services when indicated, and educational services.

B. ADMISSION/CLINICAL CRITERIA

1. The DCS Family services worker prepares the Referral Packet, which will contain the rationale for placement as well as all available current, historical, familial, psychosocial and related clinical data (e.g., measures of psychopathology, assessments of strengths and needs) regarding a youth.
2. The following criteria must be met for admission to a Level III residential program:
 - a. The youth has a significantly severe mental health disorder (DSM-IV-TR) and is impaired in social, educational, familial, and occupational functioning. This level of functioning is not due exclusively to mental retardation, organic dysfunction, or developmental disabilities. This disorder is amenable to “psychiatric treatment” and requires mental health treatment that cannot be successfully provided at a lower level of care. The youth cannot be medically stable in a most appropriate setting. The youth needs psychiatric consultation and access to physician services as well as daily supportive guidance toward stabilization.
 - b. The youth is unable to adequately care for physical needs without external support that is beyond the capacity/capabilities of the family and/or other non-inpatient community support system representatives to provide. This inability represents harm to self or others (e.g., reckless self-endangerment) and is due to psychiatric disorder *not* developmental, social, cognitive, or specific medical limitations.
 - c. The youth’s current living environment, family setting, extended community do not provide the support and access to therapeutic services necessary to maintain stability or maximize effective daily functioning and/or the youth has not been successful in lower

levels of treatment efforts (i.e., has failed to maintain or sustain adequately).

- d. The youth cannot achieve successful adaptation for the purpose of stabilization *at this time* without significant structure and supportive residential guidance that can only be provided through twenty-four (24) hour intervention and supervision in a highly structured environment..
 - e. The youth meets the age, cognitive capacity, adaptive functioning level and/or developmental level requirements necessary for minimal acceptance in the specific setting.
 - f. The youth does not require medical substance abuse treatment as the primary need, does not have contraindicated medical conditions that are primary and supersede the psychiatric symptoms, and/or has not been adjudicated as a sexual perpetrator who requires specialized treatment services in a unique setting.
- 3. Children have been identified as having moderate to severe mental health treatment needs.
 - 4. Children may be of any adjudication type.
 - 5. Children may pose a high risk for elopement, instability in behavior and mental health status, or occasionally experience acute episodes. These youth also experience persistent maladjustment of peer and other social relationships or other influencing systems, which interfere with learning and social environments.
 - 6. Children with primary diagnosis of mental retardation are evaluated on a case-by-case basis. Children with an IQ lower than 55 or who have adaptive functioning indicating moderate to severe mental retardation are not appropriate unless the agency is licensed for this service type.
 - 7. Children who are acutely suicidal or homicidal or who have psychoses not controlled with medication will be referred to inpatient psychiatric treatment through specialized crisis services. They do not have records of major acts of violence or aggression which have required incarceration within the past six (6) months.
 - 8. The provider agency may not reject children deemed appropriate for the scope of service.

C. PERSONNEL

1. The service has qualified personnel who can meet the developmental and therapeutic needs of all children accepted for care and services
2. Adequate care and supervision are provided at all times to assure that children are safe and that their needs are met in accordance with their developmental level, age, and emotional or behavioral problems.
3. The provider agency has available the services of a licensed physician on at least an on-call basis to provide and/or supervise medical care on a 24-hour basis. If this person is not a psychiatrist, then the facility must arrange for the services of a psychiatrist for regular, emergency and consultative services.

D. INDIVIDUALIZED TREATMENT PLANS

1. An initial treatment plan will be developed within three (3) days of admission. A more formalized treatment plan must be developed within seven days of admission after any needed testing or consultation has occurred.
2. The child's treatment plan will include a specific strengths-based family integration/reintegration treatment plan. It will also include guidelines for family participation while the child is at the facility. These family participant guidelines will contain frequency of family visits, whether visits are supervised, and location of visitations. The agency will work with the facility to address transportation and communication barriers. Family counseling and family visits shall not be contingent on the child's behavior. This plan for family involvement will be updated at least quarterly.
3. The treatment plan also will include all goals for educational issues, mental health needs (including therapy and psychiatric medications), substance use issues, physical/medical concerns, and family work.
4. The individual treatment plan should consider discharge goals and estimated length of stay. Discharge planning should begin at admission and be an ongoing process.

E. SERVICE COMPONENTS PROVIDED WITHIN THE PER DIEM

1. Service Components Required of All Level III Residential Programs
 - a. Twenty-four (24) hour awake staff;
 - b. Comprehensive assessment of the child to include coordination of EPSDT screening and recommended follow-up services, updated Family Functional Assessment, academic history, and psychological evaluation if needed;
 - c. Behavior management system emphasizing positive

reinforcements;

- d. Development of Individualized Crisis Management Plan if warranted by youth behavior;
- e. Social skills training;
- f. Activity therapy;
- g. Daily living skills;
- h. Daily group counseling within the context of the milieu;
- i. Group therapy conducted by an appropriately credentialed staff at a frequency determined by the treatment team
- j. Individual therapy by an appropriately credentialed staff at least weekly;
- k. Family therapy

A Family of Care—biological, relative, or foster—will be identified by the Family services worker, regional resource manager and Level III staff as soon as possible following admission to the facility if the youth does not already have a family identified. Ideally, this is the family to whom the child will go after discharge. Either in person or by telephone, the assigned therapist will meet with the Family of the Care and DCS family services worker **within the first week of admission and at least weekly thereafter** or identify valid reasons why such a plan for family involvement is not appropriate.

- l. Psychiatric evaluation or consultation upon admission and ongoing psychiatric management as needed
 - n. Attending physician must document treatment and progress resulting from a face-to-face contact at least one time per month.
 - m. Tennessee Department of Education and DCS approved educational program in compliance with all necessary educational requirements including special education services when applicable;
 - n. Nationally recognized crisis intervention program for the use of seclusion, restraint and restrictive interventions.
2. Planning for stability and permanence in the care and provision of services to each child includes assistance with recruitment of an adoptive or a long-term support family, if indicated by the child's permanency plan.

F. EDUCATION

1. There is a presumption that children who meet the criteria for placement in a Level III Residential Treatment Facility require intervention and intensive clinical treatment twenty-four (24) hours per day. Due to this high level of intervention and treatment, educational services for these children must be provided in an in-house school.
2. Prior to the child's thirtieth (30th) day in the RTC, a CFTM must be convened in order to determine the child/youth's appropriateness for continuation in the RTC. The Child and Family Team should include a local education representative and education representative and/or attorney.
3. If the CFT consensus indicates that the child/youth continues to need treatment at the RTC, the child must continue to attend the in-house school. A review and target date for completion of treatment will be established.
4. If the CFT consensus indicates that the child/youth no longer requires treatment in an RTC, then the team will set a target date for enrollment and transition to public school based on the best interest of the child.
5. The residential center has an on campus, in-house educational program, approved by the Tennessee Department of Education and the Department of Children Services.
6. Former school records are obtained promptly upon admission and up to date records are provided to the new school when the child is referred elsewhere.
7. The resident who is assessed to be ready for placement in an off-campus school setting or to be mainstreamed in a regular classroom is placed in accord with the goals and timetables of their individual educational plan.
8. Agency provides tutoring, academic enrichment or other services needed for the child to successfully achieve educational goals

G. UTILIZATION REVIEW

The agency will meet the standards outlined in Chapter One, Section I.F. except that utilization review occurs at least every 30 days.

H. DISCHARGE CRITERIA

Children/youth will be discharged according to decision of CFTM and using CFTM protocol.

III. LEVEL IV RESIDENTIAL TREATMENT

A. SCOPE OF SERVICES

Level IV is hospital-based residential care, which is a physician-directed level of care focused on establishing the behavioral and emotional prerequisites for functioning in the most appropriate, non-hospital environments. It is a transitional level of care that a child may enter as a move towards permanency from an acute admission or as a temporary admission from a lower level of care for the purpose of emotional and/or behavioral stabilization. The child's treatment team under the leadership of the physician makes decisions regarding which clinical issues are addressed on the plan of care, the sequence in which they are addressed and discharge recommendations. The use of seclusion or restraint in Level IV programs shall be directed by a licensed independent practitioner and must be in compliance with applicable statutory, Department of Children's Services, licensure, CMS and accreditation requirements. The regional psychologist must approve all admissions of children in custody to a Level IV program.

B. ADMISSION/CLINICAL CRITERIA

1. Level IV programs operated under terms of this agreement shall be designed to serve children in the custody of the Department of Children's Services (DCS) who do not meet criteria for involuntary acute psychiatric hospitalization but who continue to require specialized mental health services, which are highly structured, therapeutically intensive, and provided within a psychiatric facility.
2. The DCS Family services worker prepares the Referral Packet containing rationale for placement and historical data regarding a youth. The psychologist will first review all available historical, familial, psychosocial, and related clinical data (e.g., measures of psychopathology, assessment of strengths and needs) that is presented as justifying the request for admission in a secure, intense, and controlled residential treatment center at a Level IV status at this time.
3. The regional psychologist considers whether the following medical necessity criteria are MET:
 - a. The youth has a significantly severe mental health disorder (DSM-IV-TR) and is markedly impaired in social, educational, familial, and occupational functioning. This level of functioning is not due exclusively to mental retardation, organic dysfunction, or developmental disabilities. This disorder is amenable to "active psychiatric treatment" and requires physician-directed care that cannot be successfully provided at a lower level of care. The youth

cannot be medically stable in a most appropriate setting, requires 24-hour nursing staff on site, minimal of weekly psychiatric face-to-face consultation, and daily supportive guidance toward short-term stabilization status.

- b. The youth is unable to adequately care for physical needs without external support that is beyond the capacity/capabilities of the family and/or other non-inpatient community support system representatives to provide. This inability represents harm to self or others (e.g., reckless self-endangerment) and is due to psychiatric disorder *not* developmental, social, cognitive, or specific medical limitations.
- c. The youth's current living environment, family setting, extended community do not provide the support and access to therapeutic services necessary to maintain stability or maximize effective daily functioning and/or the youth has not been successful in lower levels of treatment efforts (i.e., has failed to maintain or sustain adequately).
- d. The youth cannot achieve successful adaptation for the purpose of short-term stabilization *at this time* without significant structure and supportive inpatient guidance that can only be provided through twenty-four (24) hour per day, seven (7) day per week regimen.
- e. The youth meets the age, cognitive capacity, adaptive functioning level and/or developmental level requirements necessary for minimal acceptance in the specific setting.
- f. The youth does not require medical substance abuse treatment as the primary need, does not have contraindicated medical conditions that are primary and supersede the psychiatric symptoms, and/or has not been adjudicated as a sexual perpetrator who requires specialized treatment services in a unique setting.

C. ADMISSIONS PROCESS

1. All referrals for level IV services for children in custody will be made to the regional well-being unit psychologists. The regional well-being unit psychologists will conduct a case review including, whenever possible, face-to-face interviews with the child and his or her caregiver to determine the appropriateness of Level IV services.
2. The psychologist will consult with the family services worker and resource manager about the appropriateness of Level IV services.
3. The psychologist, family services worker and resource manager will jointly discuss the case with the Level IV provider and decide if the child is

appropriate for a Level IV program. If deemed appropriate, an admission will be accomplished.

D. PERSONNEL

1. The agency provides a physician-directed program and has available the services of a licensed physician on a 24-hour basis.
2. The agency needs to comply with DMHDD licensing regulations (for their type of licensure) regarding ratio of children to staff.
3. Depending on the needs of the children in care, the services of qualified and appropriately credentialed professionals will be available among the agency's personnel or through cooperative arrangements.

E. INDIVIDUALIZED TREATMENT PLANS

1. An initial treatment plan will be developed within three (3) days of admission and reviewed with the regional psychologist. A more formalized treatment plan must be developed within seven days of admission.
2. The regional psychologist will be present, in person or by telephone, at the child's initial treatment team meeting. If the regional psychologist cannot be present upon notification from the provider, he/she will be provided the opportunity for input prior to the initial treatment team meeting.
3. The child's treatment plan will include a specific strengths-based family integration/reintegration treatment plan. It will also include guidelines for family participation while the child is at the facility. These family participant guidelines will contain frequency of family visits, whether visits are supervised, and location of visitations. DCS will work with the provider to address transportation and communication barriers. Family counseling and family visits shall not be contingent on the child's behavior.
4. The treatment plan also will include all goals for educational issues, mental health needs (including therapy and psychiatric medications), substance use issues, physical/medical concerns, and family work.
5. Within three (3) days of admission, a preliminary discharge plan will be drawn up through collaboration between the regional psychologist and the treatment team of the Level IV agency. This discharge plan will contain an estimate of the length of stay and discharge goals.

F. SERVICE COMPONENTS PROVIDED WITHIN THE PER DIEM

1. Service components required of all Level IV programs:
 - a. Twenty-four (24) hour awake staff;
 - b. Comprehensive assessment of the child, if not current, to include

coordination of EPSDT screening and recommended follow-up services, updated Family Functional Assessment, academic history, and psychological evaluation if needed;

- c. Behavior management system emphasizing positive reinforcements;
- d. Development of Individualized Crisis Management Plan if warranted by youth behavior;
- e. Social skills training;
- f. Activity therapy;
- g. Daily living skills;
- h. Daily group counseling within the context of the milieu;
- i. Group therapy conducted by an appropriately credentialed staff at a frequency determined by the treatment team. The treatment team is encouraged to include the regional psychologist in the treatment planning;
- j. Individual therapy by an appropriately credentialed staff at least twice weekly;
- k. Family therapy

A Family of Care—biological, relative, or foster—will be identified by the family services worker, regional resource manager and Level IV staff as soon as possible following admission to the facility if the youth does not already have a family identified. This the family to whom the child will return after discharge. Either in person or by telephone, the assigned therapist will meet with the Family of the Care and DCS family services worker within the first three (3) days of admission and at least twice weekly thereafter. Family therapy will be conducted by an appropriately credentialed professional at a frequency determined by the treatment team. Family consultation will occur at least twice weekly.

- l. Psychiatric evaluation by the treating psychiatrist within three (3) days of admission, and at least weekly contact with the psychiatrist on an ongoing basis;
- m. Tennessee Department of Education and DCS approved educational program in compliance with all necessary educational requirements including special education services when applicable;
- n. Nationally recognized crisis intervention program for the use of seclusion, restraint and restrictive interventions; and
- o. Specialized treatment needs identified by the treatment team or CFT that may not be generally available but are critical to the overall treatment, stability and success of the youth.

3 -RESIDENTIAL TREATMENT

G. EDUCATION

1. There is a presumption that children who meet the criteria for placement in hospital-based residential program require intervention and intensive clinical treatment twenty-four (24) hours per day. Due to this high level of intervention and treatment, educational services for these children must be provided in an in-house school.
2. Educational approvals are through the Tennessee Department of Education and Department of Children's Services, Education Division.
3. Prior to the child's thirtieth (30th) day in the Level IV program, a CFTM must be convened in order to determine the child/youth's appropriateness for continuation in the program. The Child and Family Team should include a local education representative and education representative and/or attorney.
4. If the CFT consensus indicates that the child/youth continues to need treatment at Level IV, the child must continue to attend the in-house school. A review and target date for completion of treatment will be established.
5. If the CFT consensus indicates that the child/youth no longer requires treatment at Level IV, then the team will set a target date for enrollment and transition to public school based on the best interest of the child.
6. The residential center has an on campus, in-house educational program, approved by the Tennessee Department of Education and the Department of Children Services.
7. Former school records are obtained promptly upon admission and up to date records are provided to the new school when the child is referred elsewhere.
8. The resident who is assessed to be ready for placement in an off campus school setting or to be mainstreamed in a regular classroom is placed in accord with the goals and timetables of their individual educational plan.
9. Agency provides tutoring, academic enrichment or other services needed for the child to successfully achieve educational goals

H. MONITORING PROGRESS

1. Progress reports will be forwarded to the family services worker, regional resource manager and regional psychologist at 14-day intervals. The agency will provide any additional information needed for the regional psychologist to review the child's progress toward treatment goals and discharge goals at these 14-day intervals. For this review, the agency will coordinate with the regional psychologist to allow for the psychologist to

participate in person or by telephone, in the child's treatment review nearest to the 14-day interval.

2. The agency will give the regional psychologist and the regional nurses access to information about psychotropic medication and seclusion and restraint instances. Level IV staff may be asked to consult with regional well-being unit staff about these issues.

I. DISCHARGE PLANNING AND DISCHARGE CRITERIA

1. A preliminary discharge plan with discharge goals, projected length of stay, and tentative aftercare plan will be formulated and shared with the DCS regional psychologist, educational specialist, family services worker, and placement specialist.
2. A youth is ready for discharge when he/she no longer meets the admission criteria (outlined above) and sufficient aftercare services (e.g., mental health, education, family,

SECTION FOUR

I. CONTINUUM OF CARE CORE REQUIREMENTS

A. Scope of Services

Continuum of Care is a service model with a focus on achieving the outcome of successful permanency for children in a family setting. Continuums have flexibility to design individualized services for children and families, in coordination with a child and family team, and the ability to customize the delivery of services to each child and family in the most appropriate manner. A continuum is an array of services for children with moderate to severe mental health and behavioral issues and their families, including:

1. residential services,
2. resource homes with wraparound services,
3. in-home services,
4. adoption services,
5. independent living services, and
6. support and services to the child's family.

The goal of all continuum services is timely permanency and well being for the children served.

B. Admissions /Clinical Services and Movement in a Continuum

Continuums must have the capacity for immediate admission of children into the program, including children who are just entering custody and for whom there is limited presenting information but initial review indicates the child's needs meet the scopes of services. Continuum providers will assist in initial assessment, planning, and service development for all children and families, within the timelines required by the Department of Children's Services.

1. Admission

At admission, initial placement is made in the most appropriate placement, given assessments, referral information, community safety, clinical services, family viability/safety, and educational needs. Any child who is admitted to the contract is treated as a full admission. Each youth and family must have access to the full range of services as identified in the child and family team meeting and follow policies related to this contract.

2. Movement

Stability in placement is a priority for all children and families. Movement of a child should be minimal, if at all. Any movement of a child must be in coordination with a Child and Family Team meeting held with all involved adults and age appropriate child. The movement should also be determined to facilitate timely permanency and in the best interest of the child and family. Should a move be necessary due to an emergency situation, the DCS family services worker must be informed and give permission prior to the move. If after hours, notification and permission must be obtained the next business day. A CFTM must be held within three (3) business days in these situations. A Notice of Action is required for any disruption, termination, or discontinuation of services. The agency, in coordination with the child and family team, must have services available that are targeted to reduce instances of disruption or moves for all children. These services should be designed specifically for children identified by presenting information or evaluations, as being at risk for disruption or move.

3. Respite

Respite is defined as a brief break in care, usually seventy-two (72) hours or less, with the child returning to the original placement. Any other placement is considered a move and reported and reviewed by a child and family team as a move.

4. Move Towards Permanency

In some cases, a client may be eligible for a more appropriate level of care currently provided by the continuum (for example, the client is Level III and now meets criteria for Level II). This decision is to be made in the context of the child and family team meeting, and there must be clear documentation and reasoning to decrease the intensity of services to the client. If the provider does not agree that a client should be transitioned, then the appeals guidelines outlined in the core section of this manual should be used.

C. PERSONNEL

1. Adequate care and supervision is provided at all times to assure that children are safe and that their needs are met, in accord with their developmental level, age, and emotional or behavioral problems, and include
 - a. at least one on duty child care worker providing continuous supervision for each living group of eight children or youth;

- b. higher adult/child ratios during periods of greater activity;
 - c. availability of additional or back up child care personnel for emergency situations or to meet special needs presented by the children in care; and
 - d. overnight awake staff at 1:8 ratio.
2. No more than five (5) experienced providers of case coordination or casework service report to one (1) supervisor.
 3. The case loads for personnel providing direct counseling and case coordination services do not exceed fifteen (15) residents, and may be adjusted according to current case responsibilities.
 4. The agency has the services of a licensed physician available on at least an on-call basis to provide and/or supervise medical care.

D. RESOURCE PARENT TRAINING

Refer to core requirements on Resource Homes.

E. INDIVIDUALIZED TREATMENT PLANS

Refer to core standards for all contract agencies.

F. SERVICE OVERVIEW

Refer to Services to all Children/Youth in Custody

G. SERVICE TO THE CHILD/YOUTH

Intensive In-Home Services

1. Providers of continuum services have the flexibility to deliver the level of services needed by the child and family in the most appropriate setting.
2. Ideally, the services may be provided in the child's home, or identified permanency person's home, with the support and services necessary, at the intensity level required for the child and family to be successfully reunified.

Face-to-Face Services/Contact

1. An essential component in intensive in-home services is face-to-face support, counseling, and coordination with the family.
2. The face-to-face contact must support the family dynamic; required contact may be with the parent only, child only, or both.
3. Face-to-face contact should focus on relationship building, ongoing

evaluation of strengths, assessment of barriers with interventions, and evaluation of goals established by the child and family team meetings.

4. The initial face-to face meeting must be within forty-eight (48) hours after child is placed in an in-home placement.
5. Minimum requirements for intensive in-home services are as follows:
 - a. two face-to-face sessions per week, or as specifically outlined and determined, and documented as a result of a child and family team meeting
 - b. staff providing services must meet all minimum requirements for education, training, and supervision as family services worker, as outlined in provider policy manual
 - c. services must be flexible and meet the needs and schedule of child and family as determined in child and family team meeting
 - d. 24/7 on-call availability for crisis response

Transition to In-Home Placements

1. For children moving to in-home placements, a child and family team meeting must occur no less than at the following intervals:
 - a. prior to transition to in-home placement
 - b. between 30 and 45 days following transition
 - c. as determined by the CFTM for ongoing evaluation and planning
 - d. at critical decision-making events for the child and family
 - e. prior to discharge from services
2. While the child remains in care (in custody), DCS will convene the meetings. When the child is released from custody, the continuum provider will be responsible for convening the meetings. (Statement under review.)
3. The provider must develop a treatment plan for in-home services in coordination with the child and family team. The plan must specify goals, action steps, intensity, and frequency of intervention with anticipated time frames to meet the goals.
4. The anticipated length of service provision will be determined by the CFT at the meeting prior to transition to in-home and reviewed following transition.
5. The provider must provide in-home services and plan for the length of service based upon these determinations.
6. Services may be anticipated to continue for a period of four (4) months but may end prior to this time frame, as determined by the

unique needs of the child and family as determined by the CFT.

7. There may be up to two extensions of one to three months each, if approved by a CFT.
8. Continuum providers work in conjunction with the DCS family service worker in order to acquire covered goods or services through flex funding to meet needs not in the scope of services.
9. The provider shall submit a report specifying the date of face-to-face visits, counseling sessions, visits, the services provided in the visits, and other coordinated services provided and progress toward all treatment goals during the time a child is in an in-home setting. These reports must be submitted to DCS on a monthly basis, or as requested by Departmental staff.
10. The provider must provide face-to-face visitation pursuant to the department's face-to-face visitation schedule (consistent with Brian A.) regardless of in-home services or the specifications as otherwise set out in the treatment plan.
11. If the services are not provided at the intensity level required by the child and family team, the department shall conduct a service review.
12. The review may determine that the service will be discontinued, or may determine that the provider shall continue to provide the intensive in-home services as contractually specified, with increased reporting/monitoring to ensure service delivery.

H. SERVICE TO THE PERMANENCY FAMILY

Family dynamics must be addressed and services outlined in the treatment plan as appropriate for the family. These services include but are not limited to

- (1) assessment of family strengths and service needs;
- (2) parenting training and mentoring;
- (3) effective relationship intervention and counseling;
- (4) marital relationship counseling;
- (5) family roles and responsibilities;
- (6) safety planning;
- (7) financial/budgeting/household management;
- (8) collaboration with other systems that impact the child;
- (9) school communication monitoring/liaison;
- (10) pro-social peer group;
- (11) EPSDT/ health coordination;

- (12) medication management coordination and education;
- (13) substance abuse assessment education and intervention;
- (14) extended informal community support services;
- (15) formal community support services;
- (16) disruption prevention;
- (17) behavior intervention;
- (18) domestic violence issues and intervention; and
- (19) setting appropriate and healthy boundaries.

I. SERVICE TO THE RESOURCE FAMILY

Refer to Services from Foster Care.

J. EDUCATION OF THE YOUTH

Agencies will comply with Section One, Core Standards, III Contract Program Requirements, O Educational Standards

K. STAFF PROFESSIONAL DEVELOPMENT

Agencies will comply with Section One, Core Standards, II Personnel Requirements

L. DOCUMENTATION /UTILIZATION REVIEW

1. The provider, in conjunction with a child and family team meeting, shall design and review implementation of an individualized treatment plan, based on the unique needs of each child and family.
2. Documentation of the child and family team meetings, recommendations, and progress toward the established goals will be maintained and reported at least monthly to the Department of Children's Services' Family Services Worker, resource management unit, involved adult, if any, and the advocacy Contractor.
3. Monthly progress reports and treatment summaries shall be completed for each child enrolled in the continuum program. Such reports shall be forwarded to the **SAT COORDINATORS**.
4. Monthly progress reports are reflective of the daily treatment notes, home visits, family and children visits and contact, coordinated meetings with departmental staff, court hearing, foster care review hearings, school liaison services, medical services, dates of parent

and sibling visitation, and outline progress and barriers toward all identified treatment needs of the child and family.

5. A continuum provider shall provide notice to DCS, an Involved Adult (if any), and the Advocacy contractor of the monthly treatment reports and Type A incident reports as required by DCS policy. The notice required by this section shall include a copy of the treatment report and, in the case of the Involved Adult, shall be accompanied by information regarding the availability of the TennCare appeals process and how to invoke that process on the child's behalf.
6. There must be a treatment plan review and update at least quarterly, or when indicated as needed by the child, family, or as a result of a child and family team meeting.
7. The frequency and intensity of interventions may vary as the needs of a child and family change or as priorities are established through the CFTM.
8. A CFTM is required, with notice to all involved adults and the child, if age twelve or above, prior to reduction, change, or termination of services.
9. For each child admitted into the continuum, the CFTM shall have identified specific milestones for the child and family as progress is made toward permanency. Movement to a lower or higher intensity of care must be fully documented through a child and family team meeting and includes required TennCare Notice of Action.
10. Documentation frequency and intensity must follow the requirements outlined in the provider policy manual for the level of service and placement type.
11. **Clinical Review.** There must be a clinical review, with all involved adults, clinical services providers, and the child in any situation when a child remains in residential treatment or group care in excess of six (6) months, continuing monthly or as determined by the child and family team, until a less restrictive service is identified and/or developed. This review is part of a child and family team meeting and includes the person(s) providing clinical services and the regional psychologist. The team will evaluate the ongoing need for residential services, develop a plan that facilitates discharge to less restrictive setting, recruitment of family support, or other services as appropriate to meet the child's clinical needs. The continuum provider requests that the child and family team be convened and developed in these circumstances.
12. **Performance Measures**

1. At least annually, the Department of Children's Services will review the agency's performance in the areas listed below. Contract expansion, contract reduction, corrective action plans, admission and referral rate, and/or termination will be determined based on agency's performance as compared to same contract types and the agency's past performance in these areas.
2. All children admitted to the contract and discharged from the continuum will become part of the provider's outcome evaluation and aftercare program. Discharge occurs when the child and family are no longer receiving reimbursable continuum services and as a result of a CFTM with all involved adults and age-appropriate child.

M. DISCHARGE CRITERIA

1. **Successful Discharge.** Discharge from the continuum to a permanency placement identified in the permanency plan is a successful discharge.
 - a. Discharge planning is a result of a CFTM and notice of action completion.
 - b. The child and family team may determine that a child should be discharged from the continuum contract, moving to a regular foster care contract with a negotiated relative planned permanency living arrangement, independent living with support family, or to adult services provided through the Department of Mental Health/Developmental Disabilities **and has successfully achieved permanency, completing continuum services and such transition best meets the needs of the child and family.**
2. **Unsuccessful Discharge.** Unsuccessful discharge is exit from the contract to a higher level of care, another agency of the same level of care, homelessness, and runaway without readmission, and detention or jail without return to the program.
 - a. The continuum of care services model is designed to implement a variety of services based on the varying needs of children and families. It is expected that discharge of a child, prior to completion of the program, will not be requested. The provider shall not request the removal of a child from the program for such reasons as noncompliance with house rules, reported lack of "motivation," or lack of progress in the program.

- b. The provider may request in writing a child and family team meeting to remove a child from the continuum program if the child has validated, diagnosed, or adjudicated behaviors, which would place him/her in the category of children who are not eligible for admission to the program. The provider shall be expected to exhaust all available means of service intervention prior to requesting such discharges.
- c. Deauthorization should be a consensus decision among the provider, all involved adults, family, age appropriate children, and the DCS family services worker. Deauthorization follows a child and family team meeting.
- d. The provider shall adhere to all state-approved guidelines for CFTM and discharge planning prior to any child's removal from the program. A notice of action is required for any determination, reduction, or suspension of services to all involved adults.
- e. The provider shall be responsible for the provision of appropriate services to children placed in detention. In such cases, the child and family shall be provided with a revised family service plan and the child shall be returned to an appropriate level within the continuum following release from detention.

II. Level II Continuum

A. ADMISSION/ CLINICAL CRITERIA

1. Children eligible for this level program have been identified by a mental health professional as having at least moderate emotional and/or behavioral problems and are in need of treatment.
2. Children may also have the following behavioral characteristics and/or treatment needs:
 - a. Substance abuse treatment needs which require intervention and targeted services but do not indicate a need for acute services or detoxification;
 - b. Children may be adjudicated delinquent, unruly, or dependent/neglect and there may be specific court imposed expectations for program intervention;
 - c. Children may have a history of chronic runaway, manipulative behaviors, have difficulty maintaining self-control, display poor self-esteem, have difficulty in securing and maintaining close relationships with others, be habitually truant from school, have difficulty in accepting authority, and may have delinquent charges or court involvement history. Some children may be in need of psychotropic medication and follow up. At this level, children typically have need of behavioral, and treatment intervention to be able to function in school, home, or the community because of multiple problems. Children requiring Level II have a need for constant adult supervision, behavioral intervention and counseling;
 - d. Children may have treatment needs due to sexual, physical, and or emotional abuse or neglect, which require specialized therapies and coordination of interventions and services. This supercedes the problem solving approach of the individual or group counseling components, which is needed by every child when it rises to the level of specialized therapy. Such therapy is provided by a licensed independent practitioner and coordinated through the provider.
3. Families of these children often have need for intervention, support, and coordination of services and may have multiple needs including need for counseling, alcohol and drug intervention, community support, mental health service coordination, domestic violence intervention, or other issues.
4. Children with a history of sexual offenses are eligible if they have successfully completed a sex offender treatment program and/or have

been deemed not to pose a serious risk to the community, by a recognized sex offender treatment professional.

5. These children have not successfully responded to less intensive interventions or have been denied admission or discharged from less intensive placements because of their emotional or behavioral problems.
6. A diagnosis of mental retardation may not be used as the sole basis to refuse admission to a child when the child's behavioral issues fall within the program's Scope of Service. Review of referrals of children with a diagnosis of mental retardation must be based on assessment of both the child's intellectual and adaptive level of functioning, using professionally accepted assessment instruments.
7. The agency may not deny admission to children who have been determined to meet the scope of services, provided the child is being placed according to his/her specific needs.
8. Children who are considered ineligible for Level II programs are those who are severely autistic, actively psychotic, diagnosed with moderate or more severe mental retardation, unless the program is designed to serve children with mental retardation, or who are actively suicidal or homicidal. Other youth who are ineligible for this level treatment program are those who have displayed major acts of violence or aggression which indicate a risk to the community, such as rape, unless the program is designed to serve sex offenders, arson, assault with a deadly weapon, murder, or attempted murder within the past six (6) months.

B. PERSONNEL

1. The service has qualified personnel who can meet the developmental and therapeutic needs of all children accepted for care and services.
2. The agency shall adhere to the personnel requirements for each placement type within the continuum, as outlined in the core standards, Foster Care, Therapeutic Foster Care, and Residential sections of this manual.

C. SERVICE OVERVIEW

1. The agency shall meet the standards set forth in Section One, Core Standards; Foster Care; Therapeutic Foster Care; and Residential.
2. Each youth and family must have access to the full range of services as identified in the Child and Family Team meeting and follow policies related to this contract. **At least 75% of children in a Level II Continuum must be in a family-based setting.**

3. The primary focus and goal of the continuum is the development and implementation of individualized, flexible services specifically designed to meet the unique needs of each child and family. A Child and Family Team meeting is the primary decision-making and case-planning tool used by the Contract Agency and Department of Children's Services staff. This process actively encourages all children and their family members, and other involved adults to participate in decisions and assessments regarding safety, placement, permanency, family strengths, and underlying needs. Child and Family Team meetings are convened at all critical decision making junctures and in development and implementation of treatment planning. Individualized service plans outline coordination of the services and resources with the needs and strengths of the family, specifying the desired outcomes and projected time frames.
4. Level II continuums develop and provide services in a flexible, Individualized manner to best meet the needs of the child and family. Service needs are determined through the utilization of Child and Family Team meetings. Services are determined through a review of expected discharge placement as indicated in the child's Permanency Plan, referral information, history, and treatment needs of the child and family.
5. All services provided are to be culturally and linguistically competent, recognizing the cultural, language, and ethnic heritage of the children and families being served. Services must be provided in the context that respects and best meets the unique cultural and ethnic needs of a child and family.

D. SERVICE COMPONENTS PROVIDED WITHIN THE PER DIEM

The following services are required within the per diem payment:

1. **Counseling.** Non-medically necessary intervention and support services in the form of individual, group, or family counseling, which address behavioral or mental health needs impairing social, educational, or psychological functioning.
 - a. **Sexual Abuse and Sexual Perpetration Intervention and Counseling.** Behavioral intervention and support services to address issues related to sexual abuse and/or sexually reactive behaviors in coordination with outpatient therapy recommendations and the needs of the child and/or family.
 - b. **Substance Abuse Counseling and Intervention.** Behavioral intervention and support services targeting issues related to

alcohol and/or drug misuse in coordination with outpatient therapy recommendations and needs of the child and/or family.

2. **Coordination of Therapy Services.** Referral and coordination of medically necessary outpatient therapy services as indicated in the child's Permanency Plan and/or prescribed to meet the mental health needs of the child.
3. **Case Management.** Case management/coordination services are provided by an individual, who at a minimum has a bachelor's degree in one of the social sciences and at least one year of social services experience. Case management includes coordination with the Child and Family Team in the development and implementation of the treatment plan and Family Service Plan, monitoring the implementation of this plan, and locating all services and placements a child and/or family may need while enrolled in the continuum. Case Management includes participating in all Child and Family Team meetings, attending all foster care review meetings, and court hearings. It also includes documenting progress, barriers and resolution to these barriers, maintaining contacts with the custody department personnel, revising the treatment plan as needed, maintaining ongoing contacts with the child and/or family, planning and implementing the progression of the child and/or family through the continuum. Child and Family Meetings will be utilized at all critical decision making points as outlined in the Engaging Families Policy.
4. **Family Services.** Services provided to family members and persons identified in the Permanency Plan or Child and Family Team meeting or who are identified as discharge options, which facilitate reunification, kinship care, permanency, or adoption. Services to families include linking families to community resources and services to increase stability and meet the goals of the permanency plan. Services to the family begin at the admission of the child into the contract and are fully incorporated into all treatment plans. Flexible funding may be requested through the Home County FSW to address the basic living needs of the family (rent, utilities, child care, etc.), or identified service needs that are not covered in the Scope of Services.
5. **Diligent Search.** This service is a search for potential family members to be a support or placement for a child and/or recruitment of family or individual to be an adoptive, resource, relative, or planned permanency living arrangement support for a child.
6. **Independent Living Services.** These services include counseling, skill building, service coordination, and life skills coaching/support that focus on facilitating the skills and support for the child to live successfully and

independently in the community. Age appropriate self-sufficiency skills must be incorporated into treatment plans for all children. Children ages fourteen (14) and above must have specific independent living skills training and development incorporated into service and treatment plans. Establishing connections with persons able to provide support throughout the child's life is an essential component of this service and to successful independence. Chaffee Independent Living Funding may be used to augment services as outlined in Independent Living Policy.

- a. **Job Placement Assistance.** Assistance provided by the Provider, contracted staff, certified guidance counselor, school system, or other approved entity, in helping a child find appropriate part or full-time employment.
 - b. **Vocational Assessments/Services/Planning/Training.** Administering and implementing vocational aptitude assessments, interest surveys, vocational planning and coaching, and vocational training. Services for vocational training and coaching may be accomplished through enrollment in vocational training courses or approved apprenticeships.
 - c. **Self Sufficiency Skill Training.** Evaluation of the level of independent living skills, with targeted training, mentoring, coaching, and teaching of skills to enable independence as part of the treatment plan and delivery.
 - d. **Development of Planned Permanency Living Arrangement Contract.** Development and signature of P.P.L.A. contract for youth, specifying relatives or adult(s) committing to ongoing support, as appropriate for the child.
 - e. **Transitional Living Services.** Career planning, enrollment preparation for post secondary education, apartment living, or other appropriate services for children moving to independence.
7. **Adoption Services.** Continuums are required to provide the full range of adoption services to all children in DCS full guardianship in the care of the Continuum whose goal is adoption. The Continuum Provider will provide full case management services (both those regular for foster care and those additional due to the child being in adoption status); perform all steps necessary to prepare the child for adoption; perform all steps necessary to provide diligent search for an adoptive family and prepare the adoptive family; perform all services necessary to place the child for adoption, including compliance with legal requirements and other binding documents, ICPC, and securing adoption assistance when the child is eligible; perform post placement services through finalization of the adoption; provide post finalization

services; respond to disruptions; and complete all required reports and procedures, including sealing of the adoption record. Continuum Providers will be reimbursed at the per diem rate for the adoption services delivered up to the date of the signing of the adoption placement agreement with an adopting family.

See Section Eight -ADOPTION

8. **Adjunct and Specialized Services.** The needs of each child and family are unique. All services must be individualized, based on the needs of the child and family and barriers identified in Child and Family Team meetings. Services may be obtained by utilizing community resources, developed by the Agency, or obtained through a subcontract arrangement. Services identified by the Child and Family Team as necessary for the child and family that are not covered in the Scope of Services may be accessed or developed through a flex funding request made by the Home County FSW. Appropriately licensed certified and supervised professionals must provide out patient, medically necessary therapy and medical services. Adjunct and Specialized Services include
 - a. **Parenting Skills Training.** Individualized coaching and training to assist parents with issues related to discipline, child development, child-rearing skills, and behavioral intervention. Services must meet the needs of the family as identified in the Permanency Plan and be available at times, locations, which best meet the family's needs.
 - b. **Dietetic and Nutrition Services.** Services that are necessary to address issues related to diabetes control, obesity, malnutrition, and/or eating disorders.
 - c. **Coordination of Medical and Nursing Services.** Coordination and documentation of all Early Periodic Screening Diagnosis and Treatment (EPSDT) services provided by a licensed physician, or licensed registered nurse, of the type and duration indicated by documented medical need.
 - d. **Crisis Intervention/Stabilization.** Services provided on a twenty-four (24) hour basis to a child and/or family experiencing a medical, mental health, parent/child interaction, or other significant emergency need. Services must, at a minimum, be provided by an individual with a bachelor's degree in one of the social sciences with one-year experience and who has supervisory access to licensed professional possessing, at a minimum, a Master's degree in one of the behavioral sciences.
 - e. **Emergency Placement Services.** Services available 24 hours a day through an on-call system that stabilizes children and

families by locating alternative short-term placement in emergency situations.

- f. **Respite.** Services to provide agency resource parents or family members appropriate periods of break in care giving. Respite is defined as a brief break in care, with the child returning to the original placement. Respite is generally seventy-two (72) hours or less in duration.
- g. **Community Support Services.** Identification, recruitment, development, and referral to community services to support the service needs of the child and/or family to maintain and facilitate permanency. Coordination with community support is an essential component of services to children and families.
- h. **Services for Developmentally Delayed Children.** Specialized services designed to address the developmental deficits and developmental skills needed and assistance with transitioning youth to adult services in coordination with the Department of Mental Health and Developmental Disabilities (DMRS).
- i. **Family Planning Counseling and Referral.** Education and guidance provided to a child and/or family regarding planning/preventing childbirth. These services may include alternatives available for pregnant teens.
- j. **Transportation Services.** Providing or coordinating transportation services to the child and/or family to ensure participation in provided services, court hearings, foster care review hearings, case related meetings, family visits and related services. Transportation over 250 miles per week, out-of-state visits, or out-of-state travel for reunification efforts may be supported by flex funding if recommended by the child and family team.
- k. **Placement Stability and Intervention.** Wraparound, emergency response, crisis intervention, or child/family specific intervention and support which stabilize placement and avoid movement or disruption. Services are available 24 hours on an on-call basis.

E. SERVICES TO THE FAMILY

When a child is in an out-of-home placement but the Permanency Plan has identified reunification with family as a goal, the agency must provide no less than two face-to-face contacts per month with the family, beginning within two weeks of admission. Visitation between the child and family, siblings, and others identified in the child's Permanency Plan must be

flexible and coordinated as outlined by the Child and Family Team meeting. Family involvement guidelines include any individual(s) identified in the Permanency Plan or as a result of a Child and Family Team meeting who are identified as a permanency or discharge option for the child.

F. EDUCATION

1. **Educational Services.** There is a presumption that children in Level II contract will attend public school. Educational services must be met through the most appropriate setting to meet the educational and treatment needs of the child. This includes both general and special education programs. Programs must operate or subcontract for self-contained educational services, if there is an exception approved for the child to attend a self-contained educational program through a Child and Family Team meeting, as outlined in Educational services policy. Providers of on-site educational programs must be approved as providers of this type of service by the Department of Children's Services. Any child receiving educational services in a self-contained (in-house) school setting must be approved for these services through a Child and Family Team review, as outlined in Department of Children's Services educational policy.
2. **Educational Liaison.** A staff person must act as liaison between the treatment program and the community-based educational system. This role will be to coordinate timely record transfer, school transition and to provide ongoing coordination and communication with the public school personnel. The liaison will act on behalf of the rights of the child to a free, appropriate public education. The Agency educational liaison coordinates, as needed, with the Department regional educational specialist and/or attorney for support or consultation. The liaison will be responsive to the needs of the school and coordinate information exchange within the limits of law and respect for the client's privacy.
 - a. Tutoring/Mentoring – these services supplement services being provided by the local school system or Provider's in-house school.
 - b. Former school records are obtained promptly upon admission and up to date records are provided to the new school when the child is referred elsewhere.

G. PLACEMENT TYPES

1. The Provider, in coordination with the Department of Children's Services staff, all involved adults, and child, as is appropriate, identifies services needed by the child and family to progress to permanent

placement out of State custody. Placement is determined through the use of this Child and Family Team meeting, which addresses the treatment needs of the child and family, child safety issues or concerns, and community safety.

2. The Provider must provide, or have an approved subcontract for the following arrays of placements:

- a. **Level II Group Care.** A group care facility, which meets the Level II Scope of Services in the *Provider Policy Manual*.

There is a presumption that children in Level II will attend public school. Educational services must be met through the most appropriate environment appropriate to meet the educational and treatment needs of the child. This includes both general and special education programs. **If a group care site operates an on-site school, the school must be approved by the State Department of Education and recognized by the Department of Children's Services.** Any child receiving educational services in a self-contained (in-house) school setting must be approved for these services through a Child and Family Team review, as outlined in Department of Children's Services educational policy.

- b. **Independent Living.** A group home with eight (8) or fewer children in one location, which meets the scope of services for Level 1 in the *Provider Policy Manual*. This level of service includes specialized independent living programs. Placement in any level 1 group care program with over eight (8) children in one location must be approved by the regional administrator and specifically recommended as the most appropriate placement site through a Child and Family Team meeting.

Children in Independent Living programs will attend public school. Educational services must be met through the least restrictive environment appropriate to meet the educational and treatment needs of the child. This includes both general and special education programs.

- c. **Therapeutic Foster Care** High intensity foster care which includes recruitment, training, and support services to resource parents trained to meet the needs of youth who are appropriate for family based care but require a higher level of behavioral intervention, case coordination, and/or counseling services. Children and resource families at this level of care require a high level of intervention, wraparound, and coordinated services to facilitate stability.

There is a presumption that children in Level II will attend public school. Educational services must be met through the most appropriate environment appropriate to meet the educational and treatment needs of the child. This includes both general and special education programs.

- d. **Foster Care** Each continuum has a separate foster care contract. When a Child and Family Team determines that the child and family do not require wraparound services, intensive behavioral intervention, and intensive case management, the team may recommend movement or transition from the continuum contract to a foster care contract.

Children in Level II foster care will attend public school. Educational services must be met through the most appropriate environment appropriate to meet the educational and treatment needs of the child. This includes both general and special education programs.

- e. **In-home Services** - a wide array of services offered to families and children placed with family members. These services are coordinated and include, but are not limited to, services identified in the permanency Plan as necessary to achieve permanency and stability for the child and family. Services must meet standards outlined in the Provider Policy Manual.

III. Level III Continuum of Care

A. ADMISSION/CLINICAL CRITERIA

The Level III Continuum of Care programs will meet all requirements stated in the Continuum of Care Core Requirements section of the provider policy manual. The following requirements will also apply to all Level III Continuums.

1. Children have mental and behavioral health issues that require 24-hour intervention and supervision.
2. Children have been identified as having moderate mental health treatment needs.
3. There is evidence of an impairment of functioning in the following settings: family, school, and community. Children in this population may have significant disturbances in environmental relationships such as severe disruptions of relationships within the family or with significant others as well as persistent maladjustment of peer and other social relationships or other influencing systems, which interfere with learning and social development.
4. Children may have a serious disturbance of affect behavior or thinking or the potential for danger to self or others. There may be evidence of serious developmental disturbances such as a failure to achieve or behavioral patterns with destructive psychological physical or social consequences.
5. The need for a therapeutic positively based milieu to provide education, socialization and/or counseling/mentoring.
6. Children may be of any adjudication type.
7. Children appropriate for this level of care may have medical or psychiatric disorders which require twenty-four (24) hour intervention and supervision such as an eating disorder, disordered thought process, brittle unstable diabetes, suicidal ideations, sexual impulse disorders or impulsive acts of aggression.
8. Children in need of this level of care may have substance abuse treatment needs but are not in need of medical detoxification.
9. Children in this service type may need evaluation and assessment for psychotropic medication and medication management.
10. Children may pose high risk for elopement, instability in behavior and mental health status, or occasionally experience acute episodes.
11. Children with primary diagnosis of mental retardation are evaluated on a case-by-case basis. Children with an IQ lower than 55 or who have adaptive functioning indicating moderate to severe mental retardation

are not appropriate unless the agency is licensed for this service type.

12. Children appropriate for this level of care shall not be in need of acute psychiatric hospitalization and/or require incarceration for major acts of violence or aggression within the past six (6) months.
13. The provider agency may not reject children deemed appropriate for the scope of service.
14. Families of these children often have serious needs for intervention, support, and coordination of services and may have multiple needs including need for counseling, alcohol and drug intervention, community support, mental health service coordination, domestic violence intervention, or other issues.

B. PERSONNEL

1. The service has qualified personnel who can meet the developmental and therapeutic needs of all children accepted for care and services.
2. The agency shall adhere to the personnel requirements for each placement type within the continuum, as outlined in the core standards, Foster Care, Therapeutic Foster Care, and Residential sections of this manual.
3. Adequate care and supervision are provided at all times to assure that children are safe and that their needs are met in accordance with their developmental level, age, and emotional or behavioral problems.
4. The provider agency has available the services of a licensed physician on at least an on-call basis to provide and/or supervise medical and mental health care on a 24-hour basis.
5. Depending on the needs of the children in care, the services of qualified professionals in various mental health disciplines, consultants and specialists in dentistry, medicine, nursing, education, speech, occupational and physical therapy, recreation, dietetics, and religion are available among the agency's personnel or through cooperative arrangements and are integrated with the core services of the agency to provide a comprehensive program
 - a. regular and specialized education;
 - b. individual therapy by a licensed clinician;
 - c. group therapy by a licensed clinician;
 - d. family therapy by a licensed clinician;
 - e. activity therapy;
 - f. specialized treatment services such as independent living training, values clarification, alcohol and drug intervention,

- sexual abuse, anger management;
- g. alcohol and drug treatment by an alcohol and drug counselor with appropriate license or certification;
- h. psychiatric: licensed psychiatrist onsite or available through local service as needed (psychiatric assessment, psychotropic review, crisis intervention).

C. SERVICE OVERVIEW

1. The agency shall meet the standards set forth in SECTION One, Core Standards; Foster Care; Therapeutic Foster Care; and Residential.
2. The primary focus and goal of the continuum is the development and implementation of individualized, flexible services specifically designed to meet the unique needs of each child and family. A Child and Family Team meeting is the primary decision-making and case-planning tool used by the Contract Agency and Department of Children's Services staff. This process actively encourages all children and their family members, and other involved adults to participate in decisions and assessments regarding safety, placement, permanency, family strengths, and underlying needs. Child and Family Team meetings are convened at all critical decision making junctures and in development and implementation of treatment planning. Individualized service plans outline coordination of the services and resources with the needs and strengths of the family, specifying the desired outcomes and projected time frames.
3. Level III continuums develop and provide services in a flexible, individualized manner to best meet the needs of the child and family. Service needs are determined through the utilization of Child and Family Team meetings. Services are determined through a review of expected discharge placement as indicated in the child's Permanency Plan, referral information, history, and treatment needs of the child and family. **At least 50% of all children in a Level III Continuum must be in a family-based setting.**
4. All services provided are to be culturally competent, recognizing the cultural, language, and ethnic heritage of the children and families being served. Services must be provided in the context that respects and best meets the unique cultural, linguistic, and ethnic needs of a child and family.

D. SERVICE COMPONENTS PROVIDED WITHIN THE PER DIEM

The following services are required within the per diem payment:

1. **Therapy.** Requires direct services in the form of individual, group, and/or family therapy and treatment planning. For programs specifically serving sex offenders, therapy must address sexual perpetration issues in addition to meeting other therapy needs. Persons providing therapy must be appropriately licensed, certified, credentialed, OR supervised and must follow State health care provider licensing guidelines.
 - a. **Sexual Abuse Therapy and Sexual Perpetration Therapy.** Therapy and intervention services to address issues related to sexual abuse and sexually reactive behaviors
 - b. **Substance Abuse Therapy.** Therapy and intervention services targeting issues related to alcohol and/or drug misuse
2. **Intensive Day Treatment.** Involves structured group activities in residential and group care, designed to encourage, direct, and instruct children in the acquisition of skills needed to develop self-sufficiency and personal competence, and prevent or reduce the need for institutionalized care. Programs must operate or subcontract for intensive day treatment services licensed through Tennessee Department of Mental Health/Developmental Disabilities, for access by children identified as needing this level of intervention.
3. **Counseling.** Non-medically necessary intervention and support services in the form of individual, group, or family counseling, which address behavioral or mental health needs impairing social, educational, or psychological functioning.
 - a. **Sexual Abuse and Sexual Perpetration Intervention and Counseling.** Behavioral intervention and support services to address issues related to sexual abuse and/or sexually reactive behaviors in coordination with outpatient therapy recommendations and the needs of the child and/or family.
 - b. **Substance Abuse Counseling and Intervention.** Behavioral intervention and support services targeting issues related to alcohol and/or drug misuse in coordination with outpatient therapy recommendations and needs of the child and/or family.
4. **Referral and coordination of medically necessary outpatient therapy services** as indicated in the child's Permanency Plan and/or prescribed to meet the mental health needs of the child.
5. **Educational Services.** Educational services must be met through the most appropriate setting to meet the educational and treatment needs

of the child. This includes both general and special education programs. Programs must operate or subcontract a self-contained educational services, if there is an exception approved for the child to attend a self-contained educational program through a Child and Family Team meeting, as outlined in Educational services policy. Providers must operate or have, through subcontract, on-site educational programs approved by the Department of Children's Services. Any child receiving educational services in a self-contained (in-house) school setting must be approved for these services through a Child and Family Team review, as outlined in Department of Children's Services educational policy.

- a. **Educational Liaison.** A staff person must act as liaison between the treatment program and the community based educational system. This role will be to coordinate timely record transfer, school transition and to provide ongoing coordination and communication with the public school personnel. The liaison will act on behalf of the rights of the child to a free, appropriate public education. The Agency educational liaison coordinates, as needed, with the Department regional educational specialist and/or attorney for support or consultation. The liaison will be responsive to the needs of the school and coordinate information exchange within the limits of law and respect for the client's privacy.
- b. **Tutoring/Mentoring.** These services supplement services being provided by the local school system or Provider's in-house school.

6. **Case Management.** Case management/coordination services are provided by an individual, who at a minimum has a bachelor's degree in one of the social sciences and at least one year of social services experience. Case management includes coordination with the Child and Family Team in the development and implementation of the treatment plan and Family Service Plan, monitoring the implementation of this plan, and locating all services and placements a child and/or family may need while enrolled in the continuum. Case Management includes participating in all Child and Family Team meetings, attending all foster care review meetings, and court hearings. It also includes documenting progress, barriers and resolution to these barriers, maintaining contacts with the custody department personnel, revising the treatment plan, as needed, maintaining ongoing contacts with the child and/or family, planning and implementing the progression of the child and/or family through the continuum. Child and Family Meetings will be utilized at all critical decision making points as outlined in the Engaging Families

Policy.

7. **Family Services.** Services provided to family members and persons identified in the Permanency Plan or Child and Family Team meeting or who are identified as discharge options, which facilitate reunification, kinship care, permanency or adoption. Services to families include linking families to community resources and services to increase stability and meet the goals of the permanency plan. Services to the family begin at the admission of the child into the contract and are fully incorporated into all treatment plans. Flexible funding may be requested through the Home County FSW to address the basic living needs of the family (rent, utilities, child care, etc.), or identified service needs which are not covered in the Scope of Services.
8. **Diligent Search.** This service is a search for potential family members to be a support or placement for a child and/or recruitment of family or individual to be an adoptive, resource, relative, or planned permanency living arrangement support for a child.
9. **Interdependent Living Services.** These services include counseling, skill building, service coordination, and life skills coaching/support which focus on facilitating the skills and support for the child to live successfully and independently in the community. Age appropriate self-sufficiency skills must be incorporated into treatment plans for all children. Children ages fourteen (14) and above must have specific independent living skills training and development incorporated into service and treatment plans. Establishing connections with persons able to provide support throughout the child's life is an essential component of this service and to successful independence. Chaffee Independent Living Funding may be used to augment services as outlined in Independent Living Policy
 - a. **Job Placement Assistance.** Assistance provided by the Provider, contracted staff, certified guidance counselor, school system, or other approved entity, in helping a child find appropriate part or full time employment
 - b. **Vocational Assessments/Services/Planning/Training.** Administering and implementing vocational aptitude assessments, interest surveys, vocational planning and coaching, and vocational training. Services for vocational training and coaching may be accomplished through enrollment in vocational training courses or approved apprenticeships.
 - c. **Self-Sufficiency Skill Training.** Evaluation of the level of independent living skills, with targeted training, mentoring,

coaching, and teaching of skills to enable independence as part of the treatment plan and delivery.

- d. Development of Planned Permanency Living Arrangement Contract. Development and signature of P.P.L.A. contract for youth, specifying relatives or adult(s) committing to ongoing support, as appropriate for the child.
- e. Transitional Living Services. Career planning, enrollment preparation for post secondary education, apartment living, or other appropriate services for children moving to independence.

10. **Adoption Services.** Continuums are required to provide the full range of adoption services to all children in DCS full guardianship in the care of the Continuum whose goal is adoption. The Continuum Provider will provide full case management services (both those regular for foster care and those additional due to the child being in adoption status); perform all steps necessary to prepare the child for adoption; perform all steps necessary to provide diligent search for an adoptive family and prepare the adoptive family; perform all services necessary to place the child for adoption, including compliance with legal requirements and other binding documents, ICPC, and securing adoption assistance when the child is eligible; perform post placement services through finalization of the adoption; provide post finalization services; respond to disruptions; and complete all required reports and procedures, including sealing of the adoption record. Continuum Providers will be reimbursed at the per diem rate for the adoption services delivered up to the date of the signing of the adoption placement agreement with an adopting family.

See Section Eight - ADOPTION

11. **Adjunct and Specialized Services.** The needs of each child and family are unique. All services must be individualized, based on the needs of the child and family and barriers identified in Child and Family Team meetings. Services may be obtained by utilizing community resources, developed by the Agency, or obtained through a subcontract arrangement. Services identified by the Child and Family Team as necessary for the child and family which are not covered in the Scope of Services may be accessed or developed through a flex funding request made by the Home County Case Manager. Appropriately licensed certified and supervised professionals must provide out patient, medically necessary therapy and medical services. Adjunct and Specialized Services include:
- a. Parenting Skills Training. Individualized coaching and training to assist parents with issues related to discipline, child

development, child-rearing skills, and behavioral intervention. Services must meet the needs of the family as identified in the Permanency Plan and be available at times, locations which best meet the family's needs.

- b. Dietetic and Nutrition Services. Services which are necessary to address issues related to diabetes control, obesity, malnutrition, and/or eating disorders.
- c. Coordination of Medical and Nursing Services. Coordination and documentation of all Early Periodic Screening Diagnosis and Treatment (EPSDT) services provided by a licensed physician, or licensed registered nurse, of the type and duration indicated by documented medical need.
- d. Crisis Intervention/Stabilization. Services provided on a twenty-four (24) hour basis to a child and/or family experiencing a medical, mental health, parent/child interaction, or other significant emergency need. Services must, at a minimum, be provided by an individual with a bachelor's degree in one of the social sciences with one-year experience and who has supervisory access to licensed professional possessing, at a minimum, a Master's degree in one of the behavioral sciences.
- e. Emergency Placement Services. Services available 24 hours a day through an on-call system which stabilize children and families by locating alternative short-term placement in emergency situations.
- f. Respite. Services to provide agency resource parents or family members appropriate periods of break in care giving. Respite is defined as a brief break in care, with the child returning to the original placement. Respite is generally seventy-two (72) hours or less in duration.
- g. Community Support Services. Identification, recruitment, development, and referral to community services to support the service needs of the child and/or family to maintain and facilitate permanency. Coordination with community support is essential component of services to children and families.
- h. Services for Developmentally Delayed Children. Specialized services designed to address the developmental deficits and developmental skills needed and assistance with transitioning youth to adult services in coordination with the Department of Mental Health and Developmental Disabilities.
- i. Family Planning Counseling and Referral. Education and guidance provided to a child and/or family regarding

planning/preventing childbirth. These services may include alternatives available for pregnant teens.

- j. Transportation Services. Providing or coordinating transportation services to the child and/or family to ensure participation in provided services, court hearing, foster care review hearings, case related meetings, family visits and related services. Transportation over 250 miles per week, out-of-state visits, or out-of-state travel for reunification efforts may be supported by flex funding if recommended by the child and family team.
- k. Placement Stability and Intervention - Wraparound, emergency response, crisis intervention, or child/family specific intervention and support which stabilize placement and avoid movement or disruption. Services are available 24 hours on an on-call basis.

E. SERVICES TO THE FAMILY

When a child is in an out-of-home placement but the Permanency Plan has identified reunification with family as a goal, the Agency must provide no less than two face-to-face contacts per month with the family, beginning within two weeks of admission. Visitation between the child and family, siblings, and others identified in the child's Permanency Plan must be flexible and coordinated as outlined by the Child and Family Team meeting. Family involvement guidelines include any individual(s) identified in the Permanency Plan or as a result of a Child and Family Team meeting who are identified as a permanency or discharge option for the child.

F. EDUCATION

1. The agency has a formal process and a designated individual for educational/school liaison and support.
2. Former school records are obtained promptly upon admission and up to date records are provided to the new school when the child is referred elsewhere.
3. Personnel from the residential center facilitate school transfers and provide consultation as needed to the professionals in off campus educational settings.
4. The agency provides tutoring, academic enrichment or other services needed for the child to successfully achieve educational goals.

G. PLACEMENT TYPES

The Provider, in coordination with the Department of Children's Services staff, all involved adults, and child, as is appropriate, identifies services needed by the child and family to progress to permanent placement out of State custody. Placement is determined through the use of a child and family team meeting, which addresses the treatment needs of the child and family, child safety issues or concerns, and community safety.

The Provider must provide, or have an approved subcontract for the following arrays of placements:

1. **Residential Treatment.** A residential treatment facility meeting Level III standards and licensing. The child requires 7 days per week/24 hours per day to develop skills necessary for daily living and to develop the adaptive and functional behavior that will allow him/her to live in a less restrictive setting. This setting offers a total milieu of therapy, active psychotherapeutic intervention, and specialized care in a restrictive and/or specialized setting. These services may include specialized intervention such as substance abuse or sexual offender intervention services. Placement in Residential Treatment must be clinically necessary and documented as the most appropriate option for treatment.

Educational services must be met through the most appropriate environment appropriate to meet the educational and treatment needs of the child. This includes both general and special education programs. Level III residential treatment programs must operate or have through subcontract, on-site educational programs approved by the State Department of Education and recognized by the Department of Children's Services. Any child receiving educational services in a self-contained (in-house) school setting must be approved for these services through a child and family team review, as outlined in Department of Children's Services educational policy.

2. **Group Care.** A residential treatment or group care facility, which meets the Level III Scope of Services in the *Provider Policy Manual*. This service type includes wilderness, alcohol and drug intervention programs, and programs with self contained educational programs. This level of service includes specialized independent living programs. Placement of a **Brian A. class member** in any Level III Group Care Program with over eight (8) children in one location must be approved by the Regional Administrator and be specifically recommended as the most appropriate placement site through a child and family team meeting.

Educational services must be met through the most appropriate environment appropriate to meet the educational and treatment needs of the child. This includes both general and special education programs. Level III residential treatment programs must operate or have through subcontract, on-site educational programs approved by the State Department of Education and recognized by the Department of Children's Services. Any child receiving educational services in a self-contained (in-house) school setting must be approved for these services through a child and family team review, as outlined in Department of Children's Services educational policy.

3. **Therapeutic Foster Care.** High intensity foster care which includes recruitment, training, and support services to resource parents trained to meet the needs of youth who are appropriate for family based care but require a higher level of behavioral intervention, case coordination, and/or counseling services. Children and resource families at this level of care require a high level of intervention, wraparound, and coordinated services to facilitate stability.

Children in therapeutic foster care will attend public school.

Educational services must be met through the most appropriate environment appropriate to meet the educational and treatment needs of the child. This includes both general and special education programs. However, when a Level III therapeutic foster care student exhibits extreme behavior in school, the program must provide whatever therapeutic supports are necessary to maintain the child in public school. If students ultimately cannot attend public school, the program must provide an optional school that is approved by the State Department of Education and recognized by the Department of Children's Services. Any child receiving educational services in a self-contained (in-house) school setting must be approved for these services through a child and family team review, as outlined in Department of Children's Services educational policy.

4. **Foster Care.** Each continuum has a separate foster care contract. When a child and family team determines that the child and family do not require wraparound services, intensive behavioral intervention, and intensive case management, the team may recommend movement or transition from the continuum contract to a foster care contract.

Children in therapeutic foster care will attend public school.

Educational services must be met through the most appropriate environment appropriate to meet the educational and treatment needs of the child. This includes both general and special education programs. However, when a Level III therapeutic foster care student exhibits

extreme behavior in school, the program must provide whatever therapeutic supports are necessary to maintain the child in public school. If students ultimately cannot attend public school, the program must provide an optional school that is approved by the State Department of Education and recognized by the Department of Children's Services. Any child receiving educational services in a self-contained (in-house) school setting must be approved for these services through a child and family team review, as outlined in Department of Children's Services educational policy.

5. **In-Home Services.** A wide array of services offered to families and children placed with family members. These services are coordinated and include but are not limited to services identified in the Permanency Plan as necessary to achieve permanency and stability for the child and family. Services must meet standards outlined in the *Provider Policy Manual*.

H. ACCESSING MEDICAL CARE ORGANIZATION (MCO) AND BEHAVIORAL HEALTH ORGANIZATION (BHO) SERVICES

1. With some limited exceptions, children in DCS care are eligible for TennCare. While in custody, and for six months after leaving custody, the MCO assignment for TennCare eligible children is TennCare Select. The MCO provides all medically necessary medical services. The Level III providers should coordinate with the MCO for these services. The BHO provides behavioral services on an outpatient basis. Because DCS residential providers also furnish residential behavioral services, coordination of outpatient services is required.
2. Determinations of when a Level III continuum provider is responsible for providing a mental health service as well as when the provider may access that service through an outside BHO provider and have it paid for directly by TennCare depends on the type of setting in which the child is placed. When a child in a level 3 continuum is being served in a residential treatment center, the continuum provider is responsible for supplying all psychiatric services (e.g., psychiatric evaluations, medication management) and all needed specialized treatment services (e.g., alcohol and drug treatment, sexual offender treatment).
3. When a child in a Level III continuum is being served in a community placement (i.e., group home, resource home), the continuum provider may access an outside BHO provider in the community to supply psychiatric services and specialized treatment services. The outside BHO provider who delivers these services would be paid via TennCare. The continuum provider does not pay for these services out of their per

diem.

4. For all children in Level III continuum programs, psychological testing can be obtained from an outside BHO provider. Continuum providers are not responsible for providing psychological testing as part of their daily per diem rate and scope of services.

IV. Level III Special Needs Continuum of Care

The Level III Special Needs Continuum of Care is designed to serve a unique population of children that cannot be served in the other continuum programs due to their special needs.

A. ADMISSION/CLINICAL CRITERIA

1. Children eligible for this level program have been identified by a mental health professional as having serious emotional and/or behavioral problems and are in need of treatment. All children are either developmentally delayed, sexual offenders, or have substance abuse-related disorders.
2. Children may also have the following behavioral characteristics and/or treatment needs:
 - a. Children have mental and behavioral health issues that require 24-hour intervention and supervision.
 - b. Children have been identified as having severe mental health treatment needs.
 - c. There is evidence of an impairment of functioning in the following settings: family, school, and community. Children in this population may have significant disturbances in environmental relationships such as severe disruptions of relationships within the family or with significant others as well as persistent maladjustment of peer and other social relationships or other influencing systems, which interfere with learning and social development.
 - d. Children may have serious disturbance of affect behavior or thinking the potential for danger to self or others. There may be the evidence of serious developmental disturbances such as a failure to achieve or behavioral patterns with destructive psychological physical or social consequences.
 - e. The need for a staff secure setting where continuous supervision is provided.
 - f. The need for a therapeutic milieu to provide reeducation, re-socialization, and/or psychotherapy.
 - g. Children may be of any adjudication type.
 - h. Children appropriate for this level of care may have medical or psychiatric disorders which require twenty-four (24) hour intervention and supervision such as an eating disorder, disordered thought process, brittle unstable diabetes, suicidal ideations, sexual impulse disorders or impulsive acts of

aggression.

- i. Children in need of this level of care may have substance abuse treatment needs but are not in need of medical detoxification.
 - j. Children in this service type may need evaluation and assessment for medication and medication management.
 - k. Children may pose high risk for elopement, instability in behavior and mental health status, or acute episodes.
 - l. Children with primary diagnosis of mental retardation are evaluated on a case-by-case basis. Children with an IQ lower than 55 or who have adaptive functioning indicating moderate to severe mental retardation are not appropriate unless the agency is licensed for this service type.
 - m. Children appropriate for this level of care, are not acutely suicidal, homicidal or do not have psychosis not controlled with medication. They do not require incarceration for major acts of violence or aggression which have occurred within the past six (6) months.
- 3. Families of these children often have serious needs for intervention, support, and coordination of services and may have multiple needs including need for counseling, alcohol and drug intervention, community support, mental health service coordination, domestic violence intervention, or other issues.
 - 4. These children have not successfully responded to less intensive interventions or have been denied admission or discharged from less intensive placements because of their emotional or behavioral problems.
 - 5. A diagnosis of mental retardation may not be used as the sole basis to refuse admission to a child when the child's behavioral issues fall within the program's Scope of Service. Review of referrals of children with a diagnosis of mental retardation must be based on assessment of both the child's intellectual and adaptive level of functioning using professionally accepted assessment instruments.
 - 6. Children who are considered ineligible for Level III programs are those who are severely autistic, actively psychotic, diagnosed with moderate or more severe mental retardation, unless the program is designed to serve children with mental retardation or who are actively suicidal or homicidal. Other youth who are ineligible for this level treatment program are those who have displayed major acts of violence or aggression which indicate a risk to the community, such as rape, unless the program is designed to serve sex offenders, arson, assault with a deadly weapon, murder, or attempted murder within the past six (6)

months.

7. The agency may not deny admission to children who have been determined to meet the scope of services.

B. PERSONNEL

1. The service has qualified personnel who can meet the developmental and therapeutic needs of all children accepted for care and services.
2. The agency shall adhere to the personnel requirements for each placement type within the continuum, as outlined in the core standards, Foster Care, Therapeutic Foster Care, and Residential sections of this manual.
3. The agency shall adhere to the personnel requirements set forth for the Level III Continuum of Care.

C. SERVICE OVERVIEW

1. The agency shall meet the standards set forth in Chapter One, Core Standards; Foster Care; Therapeutic Foster Care; Residential; and Level III Continuum.

D. SERVICE COMPONENTS PROVIDED WITHIN THE PER DIEM

See Level III Continuum.

E. SERVICES TO THE FAMILY

See Level III Continuum.

F. EDUCATION

See Level III Continuum.

G. PLACEMENT TYPES

See Level III Continuum.

SECTION FIVE UNIQUE CARE AGREEMENTS, PROGRAMS FOR SPECIAL POPULATIONS AND SPECIAL NEEDS

I. UNIQUE CARE AGREEMENTS

A Unique Care Agreement (UCA) is a service available for children who need highly specialized residential treatment programs unique to the needs of a specific child. This service is available only when there is no appropriate service available under DCS's residential services contracts

Each Unique Care Agreement and its related services must be regularly reviewed within the context of the CFTM and the regional psychologist when appropriate, in order to assess the ongoing need for the services. These services may be changed to tailor the treatment program for the special needs of the child. The treatment plan must be developed specifically to meet the needs identified in the child's permanency plan. It should be noted that a UCA is a process initiated by the CFT. However, the regional Placement

II. SPECIAL POPULATIONS LEVEL II

A. SCOPE OF SERVICES

Level II Special Population is a structured group home, residential treatment facility, or wilderness program which provides structure, counseling, behavioral intervention, and other needs identified in a child's permanency plan for youth with moderate clinical needs. The youth do not attend public school in the community for specified treatment reasons.

B. ADMISSION CRITERIA

1. The service is available to children, regardless of adjudication type whose relationship with their families or whose family situation, level of development and social or emotional problems are such that services in family or resource family would not meet the child's treatment needs, due to supervision, intervention, and/or structure needs.
2. Programs are designed for youth in need of twenty-four hour care and integrated planning addressing behavioral, emotional, or family problems and the need for progressive reintegration into family and community

living. Children in Level II Special Population have been determined to need a self-contained educational program (in-house school) by a Child and Family Team due to the clinical needs of the child.

3. Children may have completed higher levels or intensity of care and determined to be appropriate to move towards permanency.
4. Children may have history of truancy, zero tolerance and/or education failure.
5. Children may have a history of impulsive behaviors, alcohol and/or drug misuse, aggression, and moderate mental health treatment and intervention needs. Children may have patterns of runaway episodes, have difficulty maintaining self-control, display poor social skills, and/or have difficulty accepting authority.
6. Children in this level of care have behaviors, which can be treated in a non-secure setting with adult supervision and intervention.
7. Children in this level of care do not meet, on a consistent basis, the criteria for higher levels of care.
8. Children in this level of care may require outpatient therapy, medication, and medication management, which will be coordinated by the agency and integrated into treatment planning.
9. Children with developmental delays are reviewed on a case-by-case basis to determine if the child could be appropriately served by the agency. A diagnosis of mental retardation is not used as a basis to refuse admission to a child when the child's behavioral issues fall within the Level II guidelines.
10. The agency may not reject children who fall within the scope of services.
11. Children who are ineligible for this level of care are those who have displayed major acts of violence or aggression such as rape, arson, assault with a deadly weapon, murder, or attempted murder, within the past six (6) months. They pose a significant risk to the community, are not appropriate for this level of care. Children in this level of care are not actively psychotic, suicidal or homicidal.

C. PERSONNEL

1. The agency will meet the standards outlined in Level II Residential.
2. The agency has the services of a licensed physician available on at least an on call basis to provide and/or supervise medical care.

D. INDIVIDUALIZED TREATMENT PLANS

The agency will meet the standards outlined in Chapter Once, Section III.U.

E. SERVICE OVERVIEW

1. The agency shall meet the standards set forth in Chapter One, Core Standards and Level II Residential.
2. The service is provided through a team approach; the roles, responsibilities, and leadership of the team are clearly defined; and there is a system of task allocation among the team members for implementation of the service plan.

F. SERVICE COMPONENTS PROVIDED WITHIN THE PER DIEM

1. The service includes
 - a. an individually planned group living program for the child; and
 - b. specialized services, such as alcohol and drug intervention, independent living skills training, as outlined in the child's permanency plan and/or treatment plan, to meet the child's individual needs, which are integrated with the child's daily living experience.

G. EDUCATION

1. Educational services must be met through the most appropriate environment to meet the educational and treatment needs of the child. This includes both general and special education programs. Programs must operate or subcontract a self-contained educational services, if there is an exception approved for the child to attend a self-contained educational program through a child and family team meeting, as outlined in Educational services policy. Providers of on-site educational programs must be approved as providers of this type of service by the Department of Children's Services. Any child receiving educational services in a self-contained (in-house) school setting must be approved for these services through a child and family team review, as outlined in Department of Children's Services educational policy.
2. Agencies with group homes or residential treatment centers will appoint a local staff member to act as "school liaison." The agency school liaison will develop a collaborative relationship with the public school system to assist children/youth in maintaining positive and successful school experiences. The school liaison must be available during the school day to respond to public school inquiries.
3. Former school records are obtained promptly upon admission and up to

date records are provided to the new school when the child is referred elsewhere.

4. Personnel from the residential center facilitate school transfers and provide consultation as needed to the professionals in off-campus educational settings
5. Agency provides tutoring, academic enrichment or other services needed for the child to successfully achieve educational goals.
6. Agency operates a self-contained (in-house) education program in full compliance with the Department of Education and the Department of Children's Services' educational policies.

H. MONITORING PROGRESS

1. Level II Residential Programs examine the need for and appropriateness of service for clients through a Child and Family Team meeting, at least quarterly or as determined by the team, reviewing:
 - a. continued out-of-home care;
 - b. efforts for family reunification; and
 - c. the adequacy of efforts to preserve and continue the parent/child relationship when possible and in the child's interest.

I. UTILIZATION REVIEW

The agency will meet the standards outlined in Section One, I, F.

SPECIAL NEEDS PROGRAMS

III. Special Needs Level II

A. SCOPE OF SERVICES

Level II Special Needs is a structured group home or residential treatment facility specializing in treatment of youth with both developmental delays and behavioral and/or emotional disorders. The program provides structure, counseling, behavioral intervention, and other needs identified in a child's permanency plan. Children and youth may, if appropriate, attend an on-site school approved by the Department of Education and the Department of Children's Services Educational Division.

B. ADMISSION/CLINICAL CRITERIA

1. The service is available to children, regardless of adjudication type whose relationship with their families or whose family situation, level of development and social or emotional problems are such that services in family or resource family would not meet the child's treatment needs, due to supervision, intervention, and/or structure needs.
2. Programs are designed for youth in need of twenty-four hour care and integrated planning addressing behavioral, emotional, or family problems and the need for progressive reintegration into family and community living. Children in Level II Special Needs remain involved in community based schools where possible but may attend a self-contained (in-house) school if approved by a Child and Family Team meeting as the most appropriate educational setting.
3. Children may have completed higher levels or intensity of care and determined to be appropriate for transition towards permanency.
4. Children may have history of truancy but may be able to attend public school with liaison and support services provided by the agency.
5. Children may have a history of impulsive behaviors, alcohol and/or drug misuse, aggression, and moderate mental health treatment and intervention needs. Children may have patterns of runaway episodes, have difficulty maintaining self-control, display poor social skills, and/or have difficulty accepting authority.
6. Children in this level of care have behaviors, which can be treated in a non-secure setting with adult supervision and intervention.
7. Children in this level of care do not meet, on a consistent basis, the criteria for

higher levels of care.

8. Children in this level of care may require outpatient therapy, medication, and medication management, which will be coordinated by the agency and integrated into treatment planning.
9. The agency may not reject children who fall within the scope of services.
10. Children in this type of service have developmental delays and require special programming to meet their individual needs.
11. Children who are ineligible for this level of care are those who have displayed major acts of violence or aggression such as rape, arson, assault with a deadly weapon, murder, or attempted murder, within the past six (6) months. They pose a significant risk to the community and are not appropriate for this level of care. Children in this level of care are not actively psychotic, suicidal or homicidal.

C. PERSONNEL

1. The agency will meet the standards outlined in Level II Residential.

D. SERVICE OVERVIEW

1. The agency shall meet the standards set forth in Chapter One, Core Standards and Level II Residential.
2. The service provides group living experiences and a program of specialized services for each child accepted for care.

E. SERVICE COMPONENTS PROVIDED WITHIN THE PER DIEM

1. The service includes
 - a. provision for meeting the child's dependency and developmental needs;
 - b. an individually planned group living program for the child; and
 - c. specialized services, such as alcohol and drug intervention, independent living skills training, as outlined in the child's permanency plan and/or treatment plan, to meet the child's individual needs, which are integrated with the child's daily living experience.

F. EDUCATION

1. There is a presumption that children in Level II contract will attend public school or a Department of Education category I, II, or III approved school (in-house or private school). Educational services must be met through the most

appropriate environment to meet the educational and treatment needs of the child. This includes both general and special education programs. Programs must operate or subcontract a self-contained educational services, if there is an exception approved for the child to attend a self-contained educational program through a child and family team meeting, as outlined in educational services policy. Providers of on-site educational programs must be approved as providers of this type of service by the Department of Children's Services. Any child receiving educational services in a self-contained (in-house) school setting must be approved for these services through a child and family Team review, as outlined in Department of Children's Services educational policy.

2. Educational approvals are through the Tennessee Department of Education and Department of Children's Services, Education Division.
3. Agencies with group homes or residential treatment centers will appoint a local staff member to act as "school liaison." The agency school liaison will develop a collaborative relationship with the public school system to assist children/youth in maintaining positive and successful school experiences. The school liaison must be available during the school day to respond to public school inquiries.
4. Former school records are obtained promptly upon admission and up to date records are provided to the new school when the child is referred elsewhere.
5. Personnel from the residential center facilitate school transfers and provide consultation as needed to the professionals in off-campus educational settings.
6. Agency provides tutoring; academic enrichment or other services needed for the child to successfully achieve educational goals.

G. MONITORING PROGRESS

1. Level II Residential Programs examine the need for and appropriateness of service for clients through a child and family team meeting, at least quarterly or as determined by the team, reviewing
 - a. continued out-of-home care;
 - b. efforts for family reunification; and
 - c. the adequacy of efforts to preserve and continue the parent/child relationship when possible and in the child's interest.

H. UTILIZATION REVIEW

The agency will meet the standards outlined in Chapter One, Section I. F.

IV. SPECIAL NEEDS LEVEL III (refer to SPECIAL NEEDS CONTINUUM)

V. SPECIAL NEEDS LEVEL IV

A. SCOPE OF SERVICES

Level IV Special Needs is hospital-based residential care, which is a physician-directed level of care focused on establishing the behavioral and emotional prerequisites for functioning in the most appropriate, non-hospital environments. It is a transitional level of care that a child may enter as a move towards permanency from an acute admission or as a temporary admission from a lower level of care for the purpose of emotional and/or behavioral stabilization. The child's treatment team under the leadership of the physician makes decisions regarding which clinical issues are addressed on the plan of care, the sequence in which they are addressed and discharge recommendations. The use of seclusion or restraint in Level IV programs shall be directed by a licensed independent practitioner and must be in compliance with applicable statutory, Department of Children's Services, licensure, CMS and accreditation requirements. The regional psychologist must approve all admissions of children in custody to a Level IV program.

B. ADMISSION CRITERIA

1. Level IV Special Needs programs operated under terms of this agreement shall be designed to serve children in the custody of the Department of Children's Services (DCS) who do not meet criteria for acute psychiatric hospitalization, but who continue to require specialized mental health services which are highly structured, therapeutically intensive, and provided within a psychiatric facility.
2. Children comprising this population shall be dually diagnosed with an axis 1 diagnosis and moderate or severe mental retardation (I.Q. score of 55 or lower) and limitations in two (2) or more adaptive skill areas (communication, self care, home living, social skills, community use, self direction, health and safety, functional academics, leisure, and work). Children with a higher IQ and concurrent limitations in adaptive skill areas (communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, or work) may be inappropriate for admission and should be considered on a case-by-case basis.
3. Individuals with mild mental retardation (IQ below 65) and significant limitations in adaptive skills (lower scores on adaptive behavior measures of communication, self-care, or social skills than would be expected based on the I.Q. score) whose needs could be more appropriately met in a special needs unit than in a general Level IV Special Needs program may be considered for admission on a case-by-case basis. A child with any of the pervasive

developmental disorders, i.e. Autistic Disorder, Rhetts Disorder, Childhood Disintegrative Disorder, Asperger's Disorder, Pervasive Developmental Disorder may be accepted on a case-by-case basis.

4. Children appropriate for admission to a Level IV Special Needs program are between the ages of six (6) to eighteen (18) years of age, (under six years of age, on a case by case basis) meet criteria for voluntary admission to a psychiatric hospital, have a DSM-IV clinical diagnosis, and have a documented need for brief hospitalization preparatory to entering the most appropriate environments. Children may display behavioral characteristics such as exhibiting self-harm, making suicidal threats or gestures, exhibiting psychotic behaviors, exhibiting assaultive behaviors, and behavior that may require limited use of seclusion or restraint. These children may also have complex associated medical problems that require ongoing treatment and care. Some children admitted to Level IV Special Needs programs may require ongoing administration and medical supervision of psychotropic medication that will necessitate ready access to appropriately licensed professionals, pharmacy, and laboratory services. Constant adult supervision and access to licensed mental health personnel are necessary in Level IV Special Needs programs.

C. ADMISSION PROCESS

1. The regional well-being unit psychologists will conduct a case review including, whenever possible, face-to-face interviews with the child and his or her caregiver to determine the appropriateness of Level IV Special Needs services.
2. The psychologist will consult with the family services worker and resource manager about the appropriateness of Level IV Special Needs services.
3. The psychologist, family services worker and resource manager will jointly discuss the case with the Level IV provider and decide if the child is appropriate for a Level IV program. If deemed appropriate, an admission will be accomplished.

D. IDENTIFYING FAMILY OF CARE

1. A Family of Care—biological, relative or resource—will be identified by the family services worker, regional resource manager and Level IV Special Needs staff prior to a child's entry into the Level IV Special Needs program or as soon as possible following admission. This is the family to whom the child will return after discharge. The family services worker, the Level IV Special Needs staff, the regional psychologist, and the Family of Care will jointly construct a family integration/reintegration plan. This plan will include family treatment goals while the child is in the Level IV Special Needs

setting, a statement of the child's strengths and how caregivers can utilize these strengths in helping the child adjust to a family environment, and behavioral and emotional issues that may arise in the home setting and how the Family of Care can deal constructively with them. Either in person or by telephone, the assigned therapist will meet with the Family of Care and DCS family services worker within the first three days of admission and at least weekly thereafter.

E. PERSONNEL

1. The service has qualified personnel who can meet the developmental, safety and therapeutic needs of the children and the families they serve.
2. Adequate care and supervision are provided at all times in accordance with children's developmental level, age, and emotional or behavioral problems. A greater adult to child ratio is available during periods of higher acuity.
Reference Providers Manual-General Program Requirements
3. The provider agency has the services of a licensed physician available on at least an on-call basis to provide and/or supervise medical and mental health care on a 24-hour basis.
4. Depending on the needs of the children in care, the services of qualified professionals in various mental health disciplines, consultants and specialists in dentistry, medicine, nursing, education, speech, occupational and physical therapy, recreation, nutrition, and religion are available among the agency's personnel or through cooperative arrangements, and are integrated with the core services of the agency to provide a comprehensive program
 - a. regular and specialized education;
 - b. individual therapy by appropriately credentialed personnel;
 - c. group therapy by appropriately credentialed personnel;
 - d. family therapy by appropriately credentialed personnel;
 - e. activity therapy; and
 - f. specialized treatment services as prescribed by the licensed psychiatrist in the Plan of Care.

F. INDIVIDUALIZED TREATMENT PLANS

1. A treatment plan will be developed and reviewed with the regional psychologist.
2. The regional psychologist will be present, in person or by telephone, at the child's initial treatment team meeting. If the regional psychologist cannot be present upon notification from the provider, he/she will be provided the

opportunity for input prior to the initial treatment team meeting.

3. The treatment plan will contain a family integration/reintegration plan as outlined in the above section. It will also contain a statement on family participation that outlines the frequency of family visits, the conditions of those visits (e.g. supervised, unsupervised; on campus, off campus; day or overnight), and how transportation or communication difficulties will be addressed. Family counseling and family visits shall not be contingent on the child's behavior.
4. The child's treatment plan will include a specific strengths based family integration/reintegration treatment plan. It will also include guidelines for family participation while the child is at the facility. These family participant guidelines will contain frequency of family visits, whether visits are supervised, and location of visitations. Family counseling and family visits shall not be contingent on the child's behavior.
5. Within three days of admission a preliminary discharge plan will be drawn up through collaboration between the regional psychologist and the clinical director of the Level IV Special Needs provider agency. This discharge plan will contain an estimate of the length of stay and discharge goals.

G. SERVICE COMPONENTS PROVIDED WITHIN THE PER DIEM

1. Service Components Required of All Level IV Special Needs Programs:
 - a. twenty-four (24) hour awake staff;
 - b. comprehensive assessment of the child (Coordination of EPSDT screening and services psychiatric evaluation, Family Functional Assessment, academic history, behavior management system of behavioral goals, tangible and social reinforcement; including an individualized behavior support plan;
 - c. social skills training;
 - d. liaison/social services;
 - e. activity therapy;
 - f. daily living skills Group therapy;
 - g. individual therapy;
 - h. family therapy
 - i. psychiatric care
 - j. discharge planning including an initial discharge plan developed within three days of admission;
 - k. Tennessee Department of Education and DCS approved educational program; and

- I. nationally recognized crisis intervention techniques.
2. Service Components Required of Level IV Special Needs Programs When Indicated on a Plan of Care:
 - a. psychiatric care which may include psychotropic medication management;
 - b. oversight and utilization of indicated medical care (including evaluation and treatment);
 - c. psycho-educational screening to assist in addressing educational and placement needs;
 - d. Speech and language services; and
 - e. Nutritional services.

H. EDUCATIONAL PROGRAM OF RESIDENTIAL CENTERS

1. Educational Requirements are for an In-house Approved School Site.
2. Educational Approvals are through the Tennessee Department of Education and Department of Children's Services, Education Division.
3. The agency will meet the educational standards set forth for Level IV programs.

I. MONITORING PROGRESS

1. Progress reports will be forwarded to the family services worker, regional placement specialist and regional psychologist at 7-day intervals.
2. The regional psychologist will review the child's progress toward treatment goals and discharge goals at 14-day intervals. The agency will provide any additional information needed for this review
3. The regional psychologist, in person or by telephone, will participate in the child's treatment review, nearest to the 14-day interval. The agency will coordinate with the psychologist for this review.
4. The regional psychologist will review serious incident reports and seclusion/restraint reports. The psychologist will consult with the Level IV Special Needs staff in cases where seclusion/restraint procedures appear to be excessive or where seclusion/restraint procedures may have violated DCS policy. All cases of seclusion and restraint that appear to violate DCS policy will be reported to the DCS Director of Medical and Behavioral Services for further review and corrective action when necessary.
5. The regional psychologist will review medication regimen of level IV children and submit to the DCS child/adolescent psychiatrist cases in which psychotropic medications might be excessive or cases in which the uses of

psychotropic medications may violate DCS policy. The DCS staff will consult with the Level IV Special Needs medical director to determine what corrective action, if any, needs to be taken.

J. DISCHARGE PLANNING AND DISCHARGE CRITERIA

1. A preliminary discharge plan with discharge goals and projected length of stay will be formulated in collaboration with the regional psychologist the educational specialist and when applicable, the well-being advocate representative and the division of mental retardation services within three days of admission.
2. The provider will develop a preliminary discharge plan and schedule professional aftercare services inclusive of reentry/entry plan to transition into the receiving school system following the discharge staffing.
3. Discharge planning shall include a family integration/reintegration plan.

SECTION SIX PRIMARY TREATMENT CENTERS AND DETENTION

I. PRIMARY TREATMENT CENTERS

A. SCOPE OF SERVICES

1. **Primary Treatment Center.** Children referred to Primary Treatment Centers may be children in their initial state custody status, children already in state custody, and children who have been released from state custody and have been recommitted. These children display a wide range of behaviors and will be served in a Primary Treatment Center according to their individual needs.
2. **Goals/Discharge Criteria for children in Primary Treatment Centers.** Children shall not remain in a PTC past 30 days.

B. ADMISSION/CLINICAL CRITERIA

1. Children may have substance abuse intervention needs. Children may have delinquent charges, display chronic runaway behavior, display manipulative behaviors, have difficulty maintaining self-control, display poor self esteem, have difficulty in securing and maintaining close relationships with others, be habitually truant from school and have difficulty in accepting authority. Children appropriately referred to a Primary Treatment Center do not pose a significant risk to community safety.
2. At a minimum, DCS shall make available to the provider a copy of the child's commitment order, TennCare card/application, consent for routine health services, and the informed consent for psychotropic medication (if the child is currently on psychotropic medications).

C. SERVICE COMPONENTS PROVIDED WITHIN THE PER DIEM

1. Primary Treatment Centers shall provide the following services within the per diem rate:
 - a. comprehensive and uniform assessments and evaluation;
 - b. individual and family treatment upon admission;
 - c. length of assessment limited to no more than fifteen (15) days;
 - d. coordinate with families and DCS staff;

- e. home-based services designed to observe, treat and assess families;
- f. emergency care services for children returning from runaway status or in a status requiring reassessments of the appropriate level of treatment service, or direct referral to placement;
- g. flexible methods to complete assessment and treatment for children who exhibit behavioral, emotional or social problems, including in-home and foster home services;
- h. Assessment centers to provide observation, assessment and treatment;
- i. Twenty-four hour (24) awake staff is required with a 1:5 ratio during awake hours and 1:8 ratio at night;
- j. Secure treatment for children with significant alcohol and drug issues and behavioral/mental health needs;
- k. Coordination of services indicated in Early Prevention, Screening, Diagnosis, and Treatment (EPSDT) evaluation; and service
- l. Completion and coordination of all comprehensive psychological, psychosocial, psychiatric (medication and medication review), psychosexual, educational, vocational, and all other necessary evaluations as detailed below.

D. ASSESSMENT AND EVALUATION

1. **Psychological screenings** shall be administered for all children in the custody of DCS who enter the Primary Treatment Center and shall, at a minimum, consist of at least the following instruments or procedures:
 - a. A clinical interview (conducted by a licensed clinical psychologist, or conducted by a licensed psychological examiner and/or psychological examiner intern who is directly supervised by a licensed psychologist);
 - b. A review and evaluation of available Family Functional Assessment and behavioral health information.
2. **Partial psychological evaluations** shall be conducted when a child demonstrates the need for a specific test to identify or clarify dysfunctional maladaptive behavior and/or symptoms, the need for a more intensive evaluation than a screening for development of an individual treatment plan and identification of service needs, and/or the need for an evaluation as identified on the EPSDT. This evaluation may include, but is not limited to:
 - a. a clinical interview (conducted by a licensed psychological examiner, licensed clinical psychologist, or psychological examiner

- intern who is directly supervised by a licensed psychologist).
- b. a review and evaluation of available Family Functional Assessment and behavioral health information.
 - c. administration of one or more specialized instruments necessary for completion of an education or mental health diagnosis (e.g. adaptive behavior assessments necessary to determine if a child is mentally retarded). These instruments may include:
 - 1. Neuropsychological assessment measures;
 - 2. Chemical abuse/dependency assessment measures;
 - 3. Speech and language measures (e.g. articulation, expressive, receptive speech, and/or language processing deficits);
 - 4. Psychosexual functioning;
 - 5. Vocational interest or ability assessments;
 - 6. Tests of achievement, adaptive functioning, or cognitive abilities;
3. **Full psychological evaluation** is administered, if recommended, by the Well-being Unit Psychologist, prescribed by a licensed, treating mental health or medical professional or the school system **and** meets at least one of the following conditions:
- a. Child demonstrates the need for more intensive evaluation at the time of the psychological screening;
 - b. Child demonstrates the need for more intensive evaluation based on medical necessity or for development of an individual treatment plan for intensive treatment or educational needs; or
 - c. Child demonstrates the need for more intensive evaluation as identified on the EPSDT screening.
4. **A full psychological evaluation** must include, but is not limited to:
- a. A clinical interview (conducted by a licensed psychological examiner, licensed clinical psychologist, or psychological examiner intern who is directly supervised by a licensed psychologist;
 - b. A review and evaluation of available Family Functional Assessment and behavioral;
 - c. Administered tests are to include, but are not limited to: individually administered test of intelligence, an objective personality measure, a projective personality measure, a measure of academic achievement which assesses basic reading comprehension, mathematics calculation, mathematics reasoning, and written expression;
 - d. All five (5) Diagnostic and Statistical Manual, Fourth Edition (DSM-

IV) axes;

- e. If applicable, the presence of an educational disability according to the criteria set out by the Special Education Manual and Tennessee Administration Policies and Procedures Manual of the Department of Education. (Composite and subtest scores, confidence level and standard error of measurement must be reported on assessments of intelligence. Standard and percentile scores must be reported on all achievement, adaptive behavior, and developmental tests.);
- f. Recommendations to address specific referral questions and therapeutic and educational interventions as indicated.

E. INDIVIDUALIZED TREATMENT PLANS

- 1. The DCS Provider shall develop an initial treatment plan within five (5) days. The DCS provider must document and provide treatment or coordinate treatment for any identified or indicated need of any child enrolled in the program. The DCS provider, in cooperation with DCS, shall utilize TennCare to address immediate medically necessary service needs.

F. PERSONNEL (RATIO OF CHILD TO STAFF)

- 1. The following ratio of child to staff must be observed:
 - a. Twenty-four hour (24) awake staff is required with a 1:5 ratio during awake hours and 1:8 ratio at night;
 - b. Direct staff qualifications shall be in compliance with the standards identified in the Provider Policy Manual;
 - c. Training for direct service staff shall include but not be limited to:
 - (1) de-escalation;
 - (2) restraints; and
 - (3) child abuse reporting.

G. MONITORING PROGRESS

- 1. The agency will conduct a review of the child's treatment plan weekly and submit progress reports to the DCS Family Services Worker, DCS Resource Manager, Involved Adult, if any, and the Advocacy Contractor.
- 2. The agency must participate in any other review deemed necessary by DCS or the courts.
- 3. The agency must engage families, if available, through the child's stay in the PTC.

II. DETENTION CENTERS

A. SCOPE OF SERVICES

Detention Centers are secured, locked facilities designed for children who pose a risk to the community due to delinquent behaviors and charges, as outlined in Tennessee Code Annotated (T.C.A.) 37-1-114.

Goals/Discharge Criteria for children in Detention Centers. Children **will not** remain in a detention center beyond **fourteen (14) calendar** days except for children waiting for placement in a DCS Youth Development Center (YDC). Children awaiting YDC placement shall not remain in detention more than fourteen (14) days. The Regional Administrator must approve all placements in detention past fourteen (14) days. Child Placement and Private Providers Division must be notified upon admission of all children placed in detention.

B. ADMISSION CRITERIA

1. Male/female children from ages 12-18; Children must be in the custody of the Department of Children's Services (DCS) and authorized by DCS to be eligible for payment.
2. **Eligible Children:** An eligible child may be detained in a detention facility if any of the following apply:
 - a. There is probable cause the child has committed a delinquent offense constituting a crime against a person resulting in the serious injury or death of the victim or involving the likelihood of serious injury or death to such victim;
 - b. The unlawful possession of a handgun or carrying of a weapon, as prohibited by T.C.A. 39-17-1307; or
 - c. There is probable cause the child has committed any other delinquent offense involving the likelihood of serious physical injury or death, or a property offense constituting a felony, and the child
 - 1). was on probation or home placement at the time of commitment;
 - 2). is currently awaiting action on a previous alleged delinquent offense;
 - 3). is alleged to be an escapee or absconded from a juvenile facility, institution, or other court-ordered placement, or has within the previous twelve (12) months, willfully failed to appear at any juvenile court hearing, engaged in violent conduct resulting in serious injury to another person or involving the likelihood of serious injury or death, or been adjudicated delinquent by virtue of an offense constituting a

felony if committed by an adult;

- d. There is probable cause to believe the child has committed a delinquent offense;
- e. The child is alleged to be an escapee from a secure juvenile facility or institution;
- f. The child is wanted in another jurisdiction for an offense, which, if committed by an adult, would be a felony in that jurisdiction;
- g. There is probable cause to believe the child is an unruly child who has violated a valid court order or who is a runaway from another jurisdiction;
- h. In addition to the conditions listed above, there must be no less restrictive alternative, which will reduce the risk of flight or of serious physical harm to the child or to others.
- i. No children in DCS physical or legal custody shall be placed, by DCS or the contract provider in jail, correctional or detention facility unless such child has been charged with a delinquency charge or unless otherwise placed or ordered by the court.
- j. Children awaiting a YDC Placement shall not remain in Detention for more than fourteen (14) days unless justified and approved by Central Office.

3. NOT ELIGIBLE FOR DETENTION: DCS children adjudicated Dependent/Neglect or Unruly who do not meet Admissions Criteria.

C. SERVICE COMPONENTS PROVIDED WITHIN THE PER DIEM

- 1. Services to be provided:
 - a. Room and Board;
 - b. Recommended three (3) hours per day administered curricula to include education in reading and mathematics during regular school year. Regular school year refers to the established public school year for the county or municipality within which the facility operates.
 - c. Youth who are certified for special education upon admission will be referred to the Director of Special Education through the local LEA in accordance with the Tennessee Department of Education's "Education Policy and Procedures for Incarcerated Children with Disabilities."
 - d. For youth who remain incarcerated beyond 14 days (10 school days) during a regular school year, the facility will notify its licensing consultant.
 - e. Visitation providing a minimum of one (1) hour of visitation each

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week for each youth with their parent/guardian unless specifically prohibited by the juvenile court judge or his/her designee;

- f. Private communication with visitors and staff;
- g. Access to religious and/or mental health counseling and crisis intervention services as needed;
- h. Continuous supervision of living units;
- i. Medical services;
- j. Food service;
- k. Case Management/Coordination;
- l. Medication administration shall be in accordance with the **DCS Policy 20.15** Medication Administration-Storage and Disposal.
<http://www.tennessee.gov/youth/dcsguide/policies/chap20/20.15%20Medication%20Administration-Storage%20and%20Disposal.pdf>
- m. Coordinate with the home county family services worker to ensure child's medical needs are addressed.
- m. Transportation
The agency maintains the responsibility for and must provide transportation to children in the detention center including transportation to all EPSTD appointments, court appearances, as well as emergency transportation for all medical and behavioral services. The agency may request that the FSW apply for flexible funding in order to assist with transportation. Transportation needs that exceed 150 miles round-trip from the agency site must be approved or not approved in the CFTM process.

D. CASE RECORD

1. The detention facility shall be required to maintain a case record on each child that includes, at a minimum, the following information:
 - a. All verbal and written information provided by DCS concerning the child and family;
 - b. Copies of all correspondence with DCS regarding the child and family;
 - c. Documentation of the child's adjustment to the program including reports of interactions with peers, interactions with those in positions of authority, observed emotional or behavioral patterns, and reports of any disciplinary actions or offenses;
 - d. Education records generated or obtained by the provider;
 - e. Medical records generated or obtained by the provider; and

- f. Case recordings and all other documentation concerning contacts or developments.
- g. Submit weekly census of state custody children to the DCS Central Office Division of Juvenile Justice Program Coordinator.

E. ALLOWANCE

This policy does not apply to detention centers.

F. TREATMENT PLANNING AND IMPLEMENTATION

This core standard does not apply to detention centers.

G. CLOTHING

- 1. Detention Centers are not required to purchase standard clothing for children. When uniforms are required by the facility, these uniforms will be provided by the facility.

H. DISCIPLINE AND SECURITY

- 1. The use of corporal punishment and chemical restraints is prohibited. The use of mechanical restraints, pepper spray, and mace shall be restricted to cases in which the safety and security of the child or others is at risk.
 - a. In order to use pepper spray, the provider must provide certified training and education that is to be documented in each authorized staff member's personnel file.
 - b. Each time pepper spray or mace is administered, proper steps and medical attention must be administered in each occurrence to relieve the youth. Documentation must be provided in the youth's file of the medical attention and proper steps.
 - c. A time lapse between administering the pepper spray or mace and appropriate medical attention cannot be used as a punishment.

SECTION SEVEN IN-HOME SERVICES

IN-HOME SERVICE REQUIREMENTS

A. SCOPE OF SERVICES

These services include but are not limited to services identified in the Permanency Plan as necessary to achieve permanency and stability for the child and family. The services may be provided in the child's/youth's home, or identified permanency person's home, with the support and services necessary, at the intensity level required for the child/youth and family to be successfully unified.

B. ADMISSIONS/CLINICAL SERVICES

The Child and Family Team determines the appropriateness and the timing of child's move to his permanency family for in-home services.

1. For children moving to in-home placements, a child and family team meeting must occur no less than at the following intervals:
 - a. prior to transition to in-home placement
 - b. between 30 and 45 days following transition
 - c. as determined by the CFTM for ongoing evaluation and planning
 - d. at critical decision-making events for the child and family
 - e. prior to discharge from services
2. An essential component of in-home services is the face-to-face support, counseling and coordination with the child and family. Contact must support the family dynamic. Required contact may be with the parent only, child only or together and should focus on:
 - a. relationship building
 - b. on-going evaluation of strengths
 - c. assessment of barriers with interventions, and
 - d. evaluation of goals established by the child and family team meetings.
3. Minimum requirements for intensive in-home services are as follows:
 - a. two face-to-face sessions per week, or as specifically outlined and determined, and documented as a result of a child and family team meeting
 - b. staff providing services must meet all minimum requirements for education, training, and supervision as family services worker,

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as outlined in provider policy manual (Core Standards, Personnel Requirements)

- c. services must be flexible and meet the needs and schedule of the child and family as determined in child and family team meetings
- d. staff availability for 24/7 on-call crisis response
- e. family dynamics must be addressed and services outlined in the treatment plan as appropriate for the family.

C. PERSONNEL RATIO

See Core Standards.

D. RESOURCE PARENT TRAINING

See Core Standards, if applicable.

E. INDIVIDUALIZED TREATMENT PLANS

Agencies will use Core Standards and the provider must develop a treatment plan for in-home services in coordination with the child and family team. The plan must specify goals, action steps, intensity, and frequency of intervention with anticipated time frames to meet the goals.

F. SERVICE OVERVIEW

1. The anticipated length of service provision will be determined by the CFTM at the meeting prior to transition to in-home services and reviewed following transition.
2. The provider must provide in-home services for the length of time specified based upon these determinations.
3. Services may be anticipated to continue for a period of four (4) months but may end prior to this time frame, as determined by the unique needs of the child and family as determined by the CFTM.
4. There may be up to two extensions of one to three months each, if approved by a CFTM.
5. While the child remains in **care (in custody)**, DCS will convene the

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Child and Family Team meetings. When the child **is released from custody**, the provider will be responsible for convening the meetings.

6. Providers work in conjunction with the DCS family services worker in order to acquire covered goods or services through flex funding to meet needs not in the scope of services.

G. SERVICE TO THE CHILD/YOUTH

See Service to the Permanency Family, below. The services are integrated.

H. SERVICE TO THE PERMANENCY FAMILY

Services to the permanency family are defined by the child and family team and assessment of needs. Services may include but are not limited to

1. assessment of family strengths and service needs;
2. parenting training and mentoring;
3. effective relationship intervention and counseling;
4. marital relationship counseling;
5. family roles and responsibilities;
6. safety planning;
7. financial/budgeting/household management;
8. collaboration with other systems that impact the child;
9. school communication monitoring/liaison;
11. pro-social peer group;
12. EPSDT/ health coordination;
13. medication management coordination and education;
14. substance abuse assessment education and intervention;
15. extended informal community support services;
16. formal community support services;
17. disruption prevention;
18. behavior intervention;
19. domestic violence issues and intervention; and
20. setting appropriate and healthy boundaries.

I. SERVICE TO THE RESOURCE FAMILY

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See Core Standards for Standard Foster Care Service, if applicable.

J. EDUCATION OF THE CHILD/YOUTH

See Core Standards for Contract Program Requirements

K. STAFF PROFESSIONAL DEVELOPMENT

See Core Standards for Personnel Requirements

L. DOCUMENTATION/UTILIZATION REVIEW

1. The provider shall submit a report specifying the date of face-to-face visits, counseling sessions, visits, the services provided in the visits, and other coordinated services provided and progress toward all treatment goals during the time a child is in an in-home setting. These reports must be submitted to DCS on a monthly basis, or as requested by Departmental staff.
2. The provider must provide face-to-face visitation pursuant to the department's face-to-face visitation schedule (consistent with Brian A.) regardless of in-home services or the specifications as otherwise set out in the treatment plan.
3. If the services are not provided at the intensity level required by the child and family team, the department shall conduct a service review.
4. The review may determine that the service will be discontinued, or may determine that the provider shall continue to provide the intensive in-home services as contractually specified, with increased reporting/monitoring to ensure service delivery.

M. DISCHARGE CRITERIA

Discharge plans will be determined through the CFTM when the child has successfully achieved permanency and when the transition best meets the needs of the child and family.

SECTION EIGHT

ADOPTION SERVICES POLICIES AND PROCEDURES MANUAL

<http://www.state.tn.us/youth/dcsguide/policies/chap15/Adoption%20Manual.pdf>

Providers will use the above manual for adoptive placements

A. PROTOCOL FOR MAKING ADOPTIVE PLACEMENTS

1. When the permanency goal changes to a dual goal or sole goal of adoption, the DCS/provider will begin to discuss adoption with the current resource family. The family service worker (FSW)/permanency specialist (PS)/provider will begin to gather required documentation needed for the potential adoption. The FSW/PS will document in TNKids under the “Identified Pre-Adoptive Home” icon if the current resource family is willing to adopt the child.
2. Once a child has been in care for nine months and no later than immediately following TPR, the FSW/PS or provider gathers the remaining information needed to write the Pre-Placement and Presentation Summaries.
3. By the 12th month (or sooner if TPR has already occurred or placement is considered legal risk) of custody of a child with a dual or sole goal of adoption **and** the current resource family is not willing to adopt and no adoptive placement has been identified, the FSW/PS or provider serving the child will convene a Child and Family Team Meeting (CFTM) to write the Individualized Recruitment Plan and begin the process of Individualized Recruitment. Recruitment may be limited until TPR occurs but it may include reviewing child’s history to identify other family members or other significant connections in the child’s life.
4. The permanency specialist meets with the prospective adoptive family to present the Presentation Summary, to determine the child’s eligibility for adoption assistance, and to negotiate the rate if applicable. Then the PS submits the rate for approval to the specified regional adoption assistance designee.
5. The PS/FSW prepares the Intent to Adopt/Adoption Assistance Application form and has family sign to demonstrate their intent to adopt child at the rate approved during the negotiation discussion. This is a formal agreement but it is not a legal document. The child’s birth name must be used on this form; however, the family and child can choose to begin “calling” the child by the proposed adoptive name. No legal documents, school records, or insurance forms can be placed in the adoptive name until finalization. The family, child, and workers should continue to “celebrate” the adoptive placement of the child.
6. The “adoptive” family is expected to accept parental responsibility of the child and schedule medical appointments, etc. but must keep DCS/provider

updated on the child's medical and behavioral issues.

7. The permanency specialist helps the family secure an attorney and obtain an attorney fee letter and subsequent approval.
8. Attorney files petition to adopt and secures a court date.
9. The permanency specialist completes the Adoption Assistance Agreement with the family at any point prior to the court date for finalization (can be completed during the time of the Intent to Adopt/Adoption Assistance Application or at a later date). The child's adoptive name is entered on the Adoption Assistance Agreement. The family and the PS sign the Adoption Assistance Agreement upon completion but the effective date cannot be prior to the date of finalization of the adoption. The resource home board payment will continue until finalization.
10. If the current resource family is adopting the child, the adoption should be completed within 90 days of the TPR (provided the court did not issue any additional requests for information and the child has been in the home required time period). Providers will be paid their regular continuum per diem rate until finalization or up to the 91st day after TPR and are expected to continue to make the foster parent payments until finalization. If the court has caused the delay in the finalization, an extension of the per diem rate can be requested by the provider. An extension for any other "good cause" can be requested from the RA/adoption designee if it is one that is beyond the control of the provider's actions. A CFTM must be held prior to discharging a child from the continuum to discuss the case, options, and barriers to finalization. The provider must be present at the CFTM and will be able to discuss the discharge or possible extension and will know the effective date of both possibilities.
11. If the adoptive placement is a new placement, the adoption should be completed within 60 days after the end of the 6-month placement period (provided the court did not issue any additional requests for information). Providers will be paid their regular continuum per diem rate until finalization or up to the 61st day after the 6-month placement period ends and foster care payments will be made by the provider until finalization. If the court has caused the delay in the finalization, an extension of the per diem rate can be requested by the Provider. An extension for any other "good cause" can be requested from the RA/adoption designee if it is one that is beyond the control of the provider's actions. A CFTM must be held prior to discharging a child from the continuum to discuss the case, options and barriers to finalization. The provider must be present at the CFTM and will be able to discuss the discharge or possible extension and will know the effective date of both possibilities.
12. Prior to the adoption court hearing (if not already completed), the PS/FSW/provider meets with the adoptive family and signs the Adoption

Assistance Agreement. The Adoption Assistance Agreement will have only the adoptive name on the contract, but the social security number will remain the same.

13. The permanency specialist gets the certified Order of Adoption Finalization at court and takes the signed Adoption Assistance Agreement to the office to set up the Adoption Assistance Case in the child's adoptive name. The PS/FSW will notify required personnel to stop resource home board payments and begin adoption assistance payments.
14. Adoptive family can request a new Social Security number following finalization from the Social Security Administration. If a new number is given, the family must provide the new Social Security number to the permanency specialist as soon as it is received. If a new Social Security number is not given, the child's birth Social Security number will continue to be used with as many safeguards as possible.

Important Points to Remember:

- ☐ Resource home board payments continue until finalization.
- ☐ Adoption assistance payments do not start until finalization.
- ☐ Birth name remains the legal name until finalization.
- ☐ Social Security number does not change throughout the adoption process.

No pseudo Social Security numbers should ever be used.

- ☐ Social Security number can only change if the adoptive family requests and is granted a new number following finalization.
- ☐ The timeline for adoption begins when the Intent to Adopt is signed and the child and family team agrees with the adoptive placement.
- ☐ Foster-to-Adopt should be completed 90 days from TPR.
- ☐ New placement adoptions should be completed 60 days after the end of the 6-month placement period.
- ☐ Out-of-state adoptive placements must be approved through the ICPC office and will be considered resource homes until finalization.

B. Special Needs Children

Providers who have established adoption services for special needs children are able to provide adoption services to children in DCS full guardianship (and to children who are nearing full guardianship) and for whom the goal is adoption.

C. Full ADOPTION Case Management Services

The provider is able to provide the full case management services (both those that are typical for foster care and those that are additional due to the child being in adoption status);

1. perform all steps necessary to prepare the child for adoption;
2. perform all steps necessary to provide diligent search for an adoptive family and prepare the adoptive family;
3. perform all services necessary to place the child for adoption, including compliance with legal requirements and other binding documents, ICPC, and securing adoption assistance when the child is eligible;
4. perform post-placement services through finalization of the adoption;
5. provide post-finalization services;
6. respond to disruptions; and
7. complete all required reports and procedures, including sealing of the adoption record.

D. Primary Components of Adoption Services

The provider will use the applicable practices described in the *Adoption Services Policies and Procedures Manual*. This manual in its entirety can be accessed at www.state.tn.us/youth/adoption/Adoption_Services_Procedure_Manual.pdf.

E. DCS Policies on Adoption Services and Foster Care

Also to be used are the following DCS policies on adoption services and selected DCS policies on foster care services as applicable also to adoption services: www.state.tn.us/youth/policies/index.htm.

F. Steps to Adoption

1. **Identify children to be placed.** DCS and the provider will confirm which children are appropriate for adoption services and adoption placement.
2. **Ensure Termination of Parental Rights (TPR) has been obtained.** DCS will verify that all TPRs, surrenders, and appeals are finalized on all legal/birth parents. [Reference: DCS Policy 15.3]
3. **Provide copy of entire record.** DCS will allow the provider to have temporary physical access to the record for a specified period of time according to a signed agreement for use of the file. The record will be submitted to the provider within five working days of the agency's request for the record.
4. **Assess placement with siblings.** DCS and the provider will assess the placement with siblings. However, DCS must approve any separation of siblings. [Reference: DCS Policy 15.1]
5. **Therapeutically prepare the child for adoption.** The provider will prepare the child for adoption using the guidelines and criteria currently implemented by DCS. [Reference: Adoption Services Policies and Procedures Manual—*Preparing the Child for Adoptive Placement*]
6. **Pre-placement Summary and Presentation Summary**
The provider will prepare the Pre-placement Summary and the Presentation

Summary following the guidelines set forth by DCS. [Reference: Adoption Services Policies and Procedures Manual—*Preparing the Pre-placement Summary and Preparing the Presentation Summary*]

7. **Maintaining Child's Foster Care Placement**

The provider will preserve the child's current foster care placement by providing appropriate foster care management and supportive services.

8. **Monthly Progress Reports**

The provider will submit monthly progress reports on the child to DCS until finalization of the adoption.

9. **Permanency Plan, Court Reviews, and Foster Care Reviews**

The provider and DCS will ensure that all federal and state time frames are met on each child. The provider will prepare the appropriate forms (Permanency Plan, Progress Report, and/or court report) for each review. DCS will approve the Permanency Plan. Both DCS and the provider will need to have a representative at court reviews.

10. **Maintain Child Welfare Benefits in Current Status**

The provider will complete appropriate forms as updates/changes occur and forward these to the child welfare benefits worker (CWBW). At the time of adoptive placement, close TennCare in the birth name and apply for TennCare in the adoptive name. [Forms: Child Welfare Benefits (CWB) Application; CWB Determination Notification of Change in Circumstances; CWB Redetermination]

11. **Maintain TNKids**

The provider will submit all information on the child directly to the DCS keyer using a paper template or via Internet in order to maintain a current status in TNKids. This should include, but is not limited to, LEA, EPSDT (TENNderCARE), Dental, Permanency Plan, Goals, Type of Placement, and any other changes recorded in TNKids.

12. **EPSDT (TENNderCARE) and Dental Services**

The provider agency will make appointments and ensure that the child receives an EPSDT (TENNderCARE) at least yearly and a dental check at least twice a year. These medical dates must be reported on TNKids.

13. **Resource Exchange for Adoptable Children in Tennessee (REACT status)**

To register a child and/or family with REACT, the provider will complete and submit appropriate REACT forms for the child and families and provide updated information as changes occur or as they meet the criteria for REACT.

DCS Policies 15.5 Registering and Maintaining Status of Children with REACT

<http://www.tennessee.gov/youth/dcsguide/policies/chap15/15.5%20Registering%20and%20Maintaining%20Status%20of%20Children%20with%20..pdf>

14. Assess Potential Adoptive Family Resources

When the resource family is not the adoptive family, the provider agency will explore and assess potential adoptive family resources for the child through its pool of available adoptive families and REACT.

15. Recruit Adoptive Families

When the resource family is not identified as the adoptive family, the provider must request a search for adoptive family referrals through REACT. If there are no families available through REACT, the provider will prepare and implement an individual recruitment plan for the child.

16. Prepare Families with the PATH Process

The provider will provide assessment and preparation of families for adoption using the PATH process. This will include, but is not limited to, writing the home study using DCS format, obtaining fingerprint results, and registering the family with REACT. The provider will be responsible for assuring fingerprint clearances.

17. Select Family via the Selection Committee

The provider will prepare a pre-placement summary and home study, and obtain a release to share the study and convene an Adoptive Placement Selection Committee according to DCS policies and procedures. DCS must be part of the selection committee to approve/disapprove potential adoptive placements. [Reference: DCS Policy 15.2]

18. Approval of Foster Parent Adoptions

The provider will present the pre-placement summary and adoptive home study of the resource family to DCS. DCS will review and approve/disapprove the foster home for the purpose of adoptive placement.

19. Present the Child to the Family

The provider will conduct a pre-placement conference with the DCS case manager/licensed child placing agency staff serving the adoptive family when placement is being made outside the resource family. The provider/DCS/licensed child placing agency staff, as appropriate, will present information about the child to the adoptive family using the child's presentation summary, medical records, educational records, and current pictures of the child.

The agency serving the family will obtain the family's decision to commit to the child.

When placing the child with a new family, the provider, in coordination with the agency serving the family, will plan and implement a pre-placement plan for the child and family. The pre-placement plan and activities between the child and adoptive family will be conducted in accordance with the child's

developmental levels and needs.

20. **Negotiate Adoption Assistance**

The provider will discuss the child's eligibility for adoption assistance and negotiate with the adoptive family consistent with DCS policy. The provider will complete appropriate applications observing the DCS policy on determining adoption assistance. DCS will approve/deny these applications.

The provider will be responsible for all revisions and renewals until finalization of the adoption. [Reference: **DCS Policy 15.11**]

<http://www.tennessee.gov/youth/dcsguide/policies/chap15/15.11AdoptionAssistance.pdf>

21. **Adoptive Placement with the Family**

The provider will sign the adoptive placement agreements using the current DCS forms.

The provider will notify the DCS resource unit to stop foster care payments to the agency and free the foster care slot. The DCS resource unit will make appropriate changes to cease foster care payments and free the foster care slot.

The provider will report the adoptive placement of the child to REACT via the Child Status form. **NOTE: Provider is responsible for notifying the placement specialist that the child has been placed with an adoptive family.**

22. **Provide Post-placement Services until Finalization of Adoption**

The provider will conduct supervision of the home in compliance with DCS policy and will provide therapeutic services for the child and family as needed, provide information to the family's attorney for the filing of the adoption petition, and seek clearance of the Putative Father Registry. [Reference: DCS Policy 15.4]

23. **Respond to Disruptions**

The provider will coordinate services with DCS to respond to families and children experiencing a disrupted adoptive placement, and the provider will report the disruption to REACT. The provider will provide therapeutic services to the child and family and will be responsible (if the child was in 24-hour care).

24. **Report to Court**

The provider will obtain the signed consent to the adoption by DCS.

- a. The provider will prepare and submit court reports and necessary documents as required by the court using the DCS format.
- b. The provider will complete the application for a new birth certificate by adoption.

[Reference: Adoption Services Policies and Procedures Manual–

Responding to the Reference; Providing for the Issuance of a New Birth Certificate by Adoption]

25. Adoption Finalized

DCS Policy 15.8 Preparing Adoption Records for Archives

<http://www.tennessee.gov/youth/dcsguide/policies/chap15/15.8PreparingAdoptionRecordsforArchives.pdf>

The provider will attend the court hearing to finalize the adoption. The provider will report the finalization of the adoption to REACT via the Child Status form.

a. Seal adoption record and submit to Adoption Services in DCS Central Office.

Once the new birth certificate is obtained, the provider will obtain the original record from DCS. The provider will prepare and submit the record for permanent filing in compliance with DCS procedures.

[Reference: Adoption Services Policies and Procedures Manual—*Preparing the Record for Permanent Filing*]

26. Provide Post-legal Services

The provider will assist the family in securing needed post-finalization adoption services to the family.

MANDATORY POLICIES

Attachment 1

Private Provider Contract Agencies Will Adhere to the Following DCS Policies. (All collateral attachments to these policies also must be reviewed)			
#	Policy Name	Contact	Comments
1.4	Incident Reporting	Audrey Corder	Cross-reference with 31.2
9.4	Confidential Child-Specific Information	Stacy Miller	
9.5	Access and Release of Confidential Child-Specific Information	Stacy Miller	
14.24	Child Protective Services Background Checks	Emmalene Palmer	
	Best Practice Guide for Adoption	Julie Flannery	
15.5	Registering and Maintaining Status of Children with REACT	Julie Flannery	
15.8	Preparing Adoption Records for Archives	Julie Flannery	
15.11	Adoption Assistance	Julie Flannery	
16.3	Desired Characteristics of Resource Parents	Julie Flannery	
16.4	Resource Home Approval	Julie Flannery	
16.8	Responsibilities of Approved Resource Parents	Julie Flannery	
16.11	Shared Resource Homes	Julie Flannery	
16.27	Resource Parent Fourteen-Day Removal Notice and Right to Appeal	Julie Flannery	

MANDATORY POLICIES

Attachment 1

16.38	Face-to-Face Visitation with Dependent and Neglected and Unruly Children in DCS Custody	Julie Flannery	
16.43	Super Unsupervised Visitation Between Child-Youth, Family and Siblings	Julie Flannery	
16.46	Child/Youth Referral and Placements	John Johnson	
16.51	Interdependent Living Plan	Dave Aguzzi	
19.1	Suicide-Self Harm Intervention	Steven Bell/Deb Gatlin	
19.8	Referral to Division of Mental Health Adult	Tricia Lea	
20.7	TENnderCARE Early Periodic Screening Diagnosis and Treatment Standards (EPSDT)	Mary Beth Franklyn/Tricia Lea	
20.12	Dental Services	Mary Beth Franklyn/Tricia Lea	
20.15	Medication Administration-Storage and Disposal	Deb Gatlin/Tricia Lea	
20.18	Psychotropic Medication	Deb Gatlin/Tricia Lea	
20.19	Communicable Diseases	Patricia Slade	
20.21	Emergency and PRN Use of Psychotropic Medication	Deb Gatlin/Tricia Lea	
20.22	HIV and AIDS	Patricia Slade	
20.24	Informed Consent	Deb Gatlin/Tricia Lea	

MANDATORY POLICIES

Attachment 1

20.25	Health Information Records and Access	Kristi Faulkner/Patricia Slade	
20.59	Medication Error Guidelines	Deb Gatlin/Tricia Lea	
21.20	Non-Traditional Educational Settings	Mary Meador	
25.10	Behavior Management	Tricia Lea	
27.1	Use of Mechanical Restraints	Tricia Lea	(Also see 31.15 – Currently in Revision)
27.2	Seclusion	Tricia Lea	
27.3	Physical Restraint	Tricia Lea	
31.2	Responsibilities Regarding Runaways, Absconders and Escapees	Dave Anderson	Cross-reference with 1.4 Incident Reporting
31.7	Building, Preparing and Maintaining Child and Family Teams	Diane Irwin	Note: There are penalties for failing to hold CTFMs before a disruption. Providers can call CFTM with in-home services.

INFORMED CONSENT PROVIDER INFORMATION 050608

Attachment 10

treatments, risks and benefits of alternative treatment, and risks and benefits of receiving no treatment.

Note - If the youth is 16 years of age or older, he or she has the same rights as adults with respect to outpatient and inpatient mental health treatment medication decisions, and confidential information (TCA 33-8-202). The youth has the right to determine parent involvement, including any use of medication. An outpatient facility or professional may provide treatment and rehabilitation without obtaining the consent of the parent, legal guardian, or legal custodian. We ask that appropriate DCS documents indicating the youth's consent to treatment be forwarded to the DCS Regional Nurse or Youth Development Center Nurse for tracking purposes.

EXCEPTIONS to parent/legal guardian/legal custodian determination of medical care

- Youth 16 years of age or older for mental health treatment
- "Mature" 14 year old youth, determined on individual case basis by provider
- Treatment of juvenile drug abuse, a physician may use his/her own discretion in notification of the youth's parents
- Prenatal care of a minor, a physician may use his/her discretion in notification of the youth's parents
- Contraceptive supplies and information
- Treatment of sexually transmitted diseases
- Emergency medical or surgical treatment

TREATMENT REFUSAL by parent/legal guardian or youth (14 years of age or older)

You, as the health care provider, in consultation with DCS will determine:

- if the treatment or procedure is medically necessary,
- if the youth may be harmed if he/she does not receive the treatment or procedure, and
- if DCS determines that the treatment is necessary to protect the youth from harm,

THEN DCS will contact the local DCS attorney regarding the need for judicial intervention.

*We hope these guidelines are informative and helpful in your care of this youth
and we thank you for the clinical services you are providing.*

POLICIES FOR INFORMATION

Attachment 2

Private Provider Contract Agencies will use these DCS Policies for Reference and Information			
#	Policy Name	Contact	Comments
1.33	Research Proposals	Susan Mee	Policy references using children in research.
12.1	Return to Home Placement: Youth Adjudicated Delinquent	Isaiah Davis	Note agencies must request passes through DCS and include summary of youth's progress in the monthly report. Note any new contact information regarding the pass in the monthly reports. DCS makes release requests. Providers should participate in the release CFTM.
12.5	Passes For Youth Adjudicated Delinquent	Isaiah Davis	
14.15	Reporting False Allegations of Child Sexual Abuse	Irma Buchanan	Use 1-877-237-0004 to report child abuse/neglect.
14.20	Notice of Child Fatality Near Fatality	Irma Buchanan	Notify DCS.
14.25	Special Investigations	Jennifer Hamilton	SIU investigates allegation in provider placements.
16.2	MultiEthnic-InterEthnic Placement Act	Servella Terry	Note statutory requirements, prohibitions and possible sanctions.
16.19	Abuse Allegations in Foster Homes	Jennifer Hamilton/Julie Flannery	
16.20	Expedited Custodial Placements	Julie Flannery	Providers may not make expedited placements.
16.21	DCS Employees as Resource Parents	Julie Flannery	DCS employees cannot parent DCS custodial children for private agencies.
16.23	Resource Home Case Files	Julie Flannery	
16.29	Resource Home Board Rates	Julie Flannery	Providers cannot pay their resource families any

POLICIES FOR INFORMATION

Attachment 2

			less than the DCS board rates.
16.31	Permanency Planning For Children/Youth in DCS Custody	Diane Irwin	Providers should: Participate in Permanency Planning, Develop treatment plans based on the perm plan, Provide information for the FCRB to DCS through monthly reports, Receive notice on hearings and FCRBs from DCS and are encouraged to attend and help ensure children 12 and older also attend.
16.32	Foster Care Review and Quarterly Progress reports	Diane Irwin	
16.33	Permanency Hearings	Diane Irwin	
16.39	Subsidized Guardianship	Odessa Krech-Helmer	These cases are limited and typically will only apply in PPLA case of youth 14+, who have been with a family a year or more. It is important to prepare provider families that once the child leaves care through SPG, that child is no longer a part of the agency and the payment the family receives will only be what is approved through the SPG agreement.
16.48	Conducting Diligent Search	Julie Flannery	Providers should communicate any new/known relative/kin contact information to DCS so that they(DCS) may follow-up.
16.52	Eligibility for Interdependent Living and Voluntary Post-Custody Services	Dave Aguzzi	See Interdependent Living Section.
16.53	Identifying and Accessing Interdependent Living Services	Dave Aguzzi	
16.54	Provision of Voluntary Post-Custody Services to Young Adults	Dave Aguzzi	
16.55	Post Secondary Scholarships: Educational and Training Vouchers and State Funded	Dave Aguzzi	See Interdependent Living Section.

Attachment 3 - DCS Forms			
#	Form Name	Requirement	Policy Reference
0630	Resource Home Prescription Medication Record	Mandatory Form	16.8, 20.15
0689	Health Services Confirmation and Follow up Notification	Mandatory Form	16.8
0692	Resource Home Mutual Reassessment	Mandatory Form	16.8
0707	Resource Parent Annual Medical Self Report	Mandatory Form	16.8
0685	Resource Family Update Checklist	Equivalent Accepted	16.8
0706	Absconder/Runaway/Escapee Checklist		16., 31.2
0698	REACT Family Status Information	Mandatory Form	16.8
0773	Resource Home Addendum	Equivalent Accepted	16.8
0672	Shared Resource Home Authorization	Mandatory Form	16.11
0450	Notice of Removal of a Child from a Resource Home	Mandatory Form	16.27
0403	Appeal for Fair Hearing	Mandatory Form	16.27
0583	Waiver of Right to Appeal	Mandatory Form	16.27
0594	Visitation Observation Checklist		16.43
0544	Resource Home Placement Checklist		16.46
	TennCare Medical Appeal, available on TennCare web site		16.46
0543	Well-Being Information and History		20.7
0708	EPSDT Physical Examination	Used by YDC, Level IV and RTC. All other locations/levels use the Health Department document	20.7
0628	Request for Prior Approval of PRN Psychotropic Medication	Mandatory Form	20.7

POLICIES FOR INFORMATION

Attachment 2

	Scholarship		
16.56	Interdependent Living Direct Payment Allowance	Dave Aguzzi	See Interdependent Living Section.
20.3	Reporting Suspected TennCare Fraud or Abuse	Mary Beth Franklyn	Agencies will have reporting information in policy.
20.9	Court Advocate Program	Stacy Miller, Irma Buchanan, & Patricia Slade	Health Services, Core Standards
21.14	Serving the Education Needs of the Child-Youth	Mary Meador	
21.16	Rights of Foster Child with Disabilities and IDEA	Mary Meador	
21.18	Notification to School Principals of Certain Delinquency Adjudications	Isaiah Davis/Mary Meador	
24.10	Title VI Program and Complaint Process	Steve Hovies	Note: Providers need to have Title VI process in place.
24.11	Grievance Procedures For Youth in DCS Group Homes	Becky Phelps	A grievance process similar to this must be in place in residential placements. Agencies can determine their own process. Insure all staff know children cannot be denied access to their attorney or GAL.
24.13	Access to Legal Counsel For Youth in DCS Group Homes	Becky Phelps	
31.15	Transportation of Children/Youth by Regional and Field Services Employees	In revision	
32.	HIPAA	Kristi Faulkner	Agencies must adhere to HIPAA Guidelines and may use this as guide.

Attachment 3 - DCS Forms			
#	Form Name	Requirement	Policy Reference
0741	Database Search Results	Mandatory Form	14.24
0695	REACT Child Entry Information	Mandatory Form	15.5
0696	REACT Child Status Information	Mandatory Form	15.5
0677	Closed Adoption Case Record Face Sheet	Mandatory Form	15.8
0422	Mailing and Acknowledging Case Record, Record Materials and Forms	Mandatory Form	15.8
0460	Intent to Adopt and Application for Adoption Assistance	Mandatory Form	15.11
0674	Special or Extraordinary Rate Request	Mandatory Form	15.11
0431	Monthly Family Income and Expenditures	Equivalent Accepted	16.3, 16.4
0678	Resource Parent Medical Report	Equivalent Accepted	16.3, 16.4
0690	Resource Home Study Verifications Checklist	Equivalent Accepted	16.4
0691	Fingerprint Card Information	Equivalent Accepted	16.4
0687	Internet Records Clearance	Equivalent Accepted	16.4
0676	Home Safety Checklist	Equivalent Accepted	16.4
0427	Child's Medical Record	Equivalent Accepted	16.4
0673	Resource Parent Oath of Confidentiality	Equivalent Accepted	16.4
0670	Oath to Report Suspected Child Abuse or Neglect and to Abide by Child Safety Restraint Laws	Equivalent Accepted	16.4
0553	Discipline Policy	Equivalent Accepted	16.4
0697	REACT Family Entry Information	Mandatory Form	16.4
0675	Resource Family Cover Sheet	Equivalent Accepted	16.8

Attachment 3 - DCS Forms			
#	Form Name	Requirement	Policy Reference
0206	Authorization for Routine Health Services for Minors		20.7
0593	Medication Observation Record	Equivalent Accepted	20.15
0627	Informed Consent for Psychotropic Medication	Mandatory Form	20.24
0629	Psychotropic Medication Evaluation	Mandatory Form	20.24
0158	Notification of Equal Access to Programs and Services and Grievance Procedures		24.10
0636	Title VI Complaint		24.10
BI-0083	TBI Missing/Wanted Person Report		31.2
0156	Violation Report		31.2
0706	Runaway/Escapee Checklist		31.2
0705	Absconder Recovery		31.2
0749	Penalty Letter for Harboring		31.2
0761	Independent Living Program Review Request	Mandatory Form	16.52, 16.54, 16.56
0778	Application for Post Custody Services	Mandatory Form	16.54
0559	Authorization for Release of Child-Specific Information from DCS and Notification of Release	Mandatory Form	16.54
0542	Research Involving Study of Existing Records or Data	Mandatory Form	6.1
0334	Request for Access to human Subjects or Records, which may involve Informed Consent	Mandatory Form	6.1
0541	Request for Information	Mandatory Form	6.1

Resource Home Eligibility Team (RHET) Protocol

Section I: Overview

In accordance with DCS and provider policy, private providers have full responsibility for ensuring the approval and continued eligibility of their resource homes. Providers must also adhere to all other applicable DCS policies, as well as the Provider Policy Manual, which outlines professional best practice. A provider's resource home is not considered approved and eligible to receive children for placement until **all** these State requirements are met.

In addition to the approval requirements mandated by both Tennessee Code Annotated as well as DCS policy and procedure, resource homes must also meet all applicable Federal requirements for eligibility. DCS has implemented an initiative to address this issue, the **Resource Home Eligibility Team (RHET)**. This initiative will allow the Department the ability to maintain all documents relating to the IV-E eligibility of provider resource homes in accordance with Federal statute surrounding the State's draw-down of IV-E funding. Adhering to the Federal guidelines outlined in the IV-E Plan allows the Department to assure providers continued payment for services rendered.

The Resource Homes Eligibility Team (RHET) will be responsible for reviewing and maintaining IV-E eligibility documents of each provider resource home both initially (new homes) and annually through the re-evaluation process. In addition, RHET will review the home studies that are submitted as part of the eligibility and maintenance requirement.

RHET will consist of a Program Coordinator and a Program Specialist. The positions will be a part of the Child Placement & Private Providers Division (CPPP). The Coordinator will supervise this process as well as the Program Specialist position. The team will provide oversight and **confirmation** of provider resource home eligibility.

Section II: Possible Payment Recovery

As stated earlier, providers are responsible for assuring that their resource homes meet eligibility criteria for Title IV-E reimbursement. **RHET is only concerned with receiving documentation that addresses Federal IV-E requirements. Please be aware that providers will remain completely responsible for assuring and maintaining all resource home requirements as per DCS policy and Provider Policy. The initial approval of a new resource home will follow the provisions of DCS Policy 16.4. Guidelines for the annual re-approval of the home will follow the provisions of DCS Policy 16.8. Both of these policies became effective March 5, 2007. However, the effective date for any applicable payment recovery recommendations was set for October 1, 2007. This was in order to allow providers ample time to review and become familiar with any new and/or revised policies affecting resource home approval.**

All required eligibility documentation must be submitted to RHET for review within **ten (10) business days** of the date the provider approved the home in the Web Application. Documentation submitted to RHET is to be provided via e-mail to CPPP or by mail.

Payment recovery recommendations will be calculated for non-compliance under the following provision: If a child (or children) is/are placed in a **provider-approved home** and that home is later found by RHET review to be ineligible, payment recovery recommendations will be made.

Payment recovery will be calculated as follows:

(Per-Diem Rate) X (# of Children in the Home) X (Period of Ineligibility) = Payment recovery

Example: A resource home provides care for a sibling group of 3 with a per-diem rate of \$35.00 per child and the home was out of compliance for 4 days. Applying the formula above, the penalty would be assessed as follows.

\$35.00 (Per Diem) X 3 (Children in Home) = \$105.00

\$105.00 X 4 (Period of Ineligibility) = \$420.00 (Penalty).

The length of the ineligibility period will be date-driven. Example: A home is approved (or re-approved) and declared by the provider to be ready for child placement on **10/01/07**. The subsequent RHET review on **10/07/07** discovers that a required background check is missing or incomplete. The missing documentation is then not submitted to RHET by the provider until **10/15/07**. The period of ineligibility in this scenario would be the period of time from **10/1/07** thru **10/15/07**. (You must provide RHET with copies of all new home approvals or annual re-assessments within 10 days of the approval date recorded in TNKids. See section IV, A #4 and B #1 below)

Section III: Appeals of Recovery Recommendations

Providers for whom recovery recommendations are made are afforded an avenue for redress by way of formal appeal. The following is the accepted process for the filing, handling and resolution of these appeals.

Recovery recommendations involving payments to providers for services rendered are made, in most cases, due to the following reasons:

1. A resource home is approved in the Web Application (by a provider), and children have been placed in the home, prior to all background checks required by DCS policy and IV-E safety requirements being completed.
2. The documentation required, by DCS policy or Federal IV-E guidelines, to support a home approval or re-approval decision is incomplete and children are placed in the home for services.

In order to appeal payment recovery recommendations based on any of the above, the provider agency must submit clear evidence that the absent or late documentation was indeed completed prior to the approval date recorded in the Web Application. It must also be evident that the documentation was obtained prior to custodial children being placed in the home for services. This appeal must come in writing (either electronically or by carrier mail) and must be submitted to RHET no later than five (5) working days after the agency's receipt of recovery notification from RHET.

Appeals or requests to reverse an unapproved period in order to allow an agency to invoice for services provided must document that the approval period entry date was late due to no fault of the agency. System malfunctions in the Web Application that prevent timely data entry will be considered.

Appeal requests and documentation to support the appeal will be submitted and processed as follows:

1. Initial appeal requests and all collateral documentation shall be submitted to the RHET representative responsible for the initial review of the agency. Appeals must come in writing (either electronically or by mail) and must be submitted to RHET no later than five (5) working days after the agency's receipt of the initial RHET recovery notification. If, after comprehensive review, the RHET representative finds that documentation was indeed timely according to established RHET protocol, the payment recovery recommendation will be cancelled or reversed.

The RHET representative shall then immediately notify, in writing, the following parties regarding the reversal decision: appealing agency's upper management contact (CEO, Executive Director, etc.), DCS Director of Fiscal Services, DCS Assistant Director for Child Placement and Private Providers (CPPP).

2. If after review, the RHET representative finds that the recovery recommendations are justified, the same parties are to be notified in writing immediately.

If after being initially denied, the agency continues to feel the recommendations have been made in error, they may then notify the RHET representative of continued appeal. The RHET representative who initially reviewed the appeal shall then forward the information to the Assistant Director for CPPP. The Assistant Director will then review the appeal, engaging additional DCS upper management personnel as needed.

If during this second tier of review the CPPP Assistant Director finds the agency's documentation does satisfy the guidelines set forth in DCS policy as well as federal IV-E safety requirements, the appeal will be upheld and all parties are to be notified immediately. At this point, all recovery recommendations will be cancelled or reversed.

If, after review, it is determined by the CPPP Assistant Director that the recovery recommendation is justified, the following entities will be contacted immediately: appealing agency's upper management contact (CEO, Executive Director, etc.) and DCS Director of Fiscal Services, DCS Assistant Director for Child Placement and Private Providers (CPPP). All recovery recommendations in the original discovery will then remain in effect.

Section IV: Resource Home Web Application

The current Resource Homes Web Application will be used in this process. The Department's Office of Information Systems (OIS) group will be required to make some adjustments to the current system that would allow the following operations:

A. Initial Approval of New Resource Homes:

1. Providers will be responsible (as they currently are) for entering information into the Resource Homes Web Application system relative to a new provider resource home.

2. RHET will receive an e-mail notification generated from the Resource Homes Web Application upon a new resource home being added and approved by a provider. The home will then be classified as "Approved" in the system. The Department will then consider the **provider-approved** home eligible to receive children.

Note: Providers should not add resource homes to the system until all pertinent DCS and Federal requirements for placement eligibility (all applicable background checks etc.) have been met. Failure to meet all requirements will result in ineligible placement of children and financial implications. (See Section III)

3. Background checks submitted for new resource home approval by providers must not be dated before the activation date recorded in TNKids. (The activation date is the date in which the resource home family expressed an interest in becoming a resource parent and submitted an application).
4. It is recommended that the period between the activation date and the approval date be no more than six (6) months to ensure that the most current background information is available at the time of approval.
5. Providers will have **ten (10) business days** from the date they approved the home in the Web Application to submit the required eligibility documentation to RHET for review and maintenance. Documentation is to be provided via e-mail to CPPP or by carrier mail. Payment recovery will be recommended for non-compliance with this provision. **The length of the overdue period subject to payment recovery will be date driven. Example: If a resource home is approved on Tuesday April 1, 2008, the packet is due to RHET no later than Tuesday April 15, 2008. Should the packet be received on April 18, 2008 and children are placed in the home, the payment recovery period will begin on the date the packet was due to RHET (April 15) until the date received (April 18). In this scenario, if the packet was received on Friday, April 18 the payment recovery period would be three (3) days multiplied by the daily per-diem rate.**
6. RHET will "freeze" the resource home if their review of the required documentation signifies the home is not an eligible home. At this time, the resource home would be considered ineligible for the placement of children. Notification of freeze action will be forwarded electronically to the agency's supervisory staff.
7. RHET will notify the following parties if a home is identified as ineligible: Private Provider, Regional Administrator, CPPP Regional Coordinator, Assistant Director and the Regional Placement Services Division (PSD).
8. The private provider, in conjunction with the Regional PSD, will then transition any and all children placed in the ineligible home based on the guidance derived from the CFTM. If the decision is made to move the child(ren) it is the responsibility of the provider to provide a safe, stable and currently eligible placement **within their own resource home network**. All appropriate Departmental placement requirements must be followed as this transition takes place.
9. If a child(ren) is placed in a **provider-approved home** and that home is later found by RHET review to be ineligible, payment recovery will be assessed (see Section III, Possible Payment Recovery).

10. RHET will maintain all resource home eligibility documentation electronically using a standardized format for identifying each home (resource home name, agency, date, etc.).

B. Re-Evaluation Process for Resource Homes

1. The annual Resource Home Re-Evaluation process will be in accordance with DCS Policy 16.8 effective October 1, 2007. Providers will have **10 business days** from the date they re-approved the home in the Web Application to submit the required eligibility documentation to RHET for review and maintenance. Documentation to be provided via e-mail to CPPP or by carrier mail. Payment recovery penalties will be assessed for non-compliance with this provision.
2. The Resource Homes Web Application will alert RHET and the provider agency of each resource home that is due for its annual re-evaluation **45 calendar days** before the date the re-evaluation is due. The eligibility of this home to receive referrals will not change during this time.
3. Background checks identified in DCS Policy 16.8 as being required for the annual resource home re-assessment must not be dated more than **45 calendar days** prior to the resource home's 12th month approval anniversary date.

(Example: If the home is due for annual re-approval on July 13, 2007, the applicable background checks must be dated prior to May 29, 2007. The **45 calendar days** corresponds with the alert period described in Item B.2 above.)
4. If the provider fails to approve the home at the one year mark, RHET and the provider will be notified by the system.
5. The private provider, in conjunction with the Regional Placement Support Division (PSD), will then transition any and all children placed in the ineligible home based on the guidance derived from the CFTM. If the decision is made to move the child(ren) it is the responsibility of the provider to provide a safe, stable and currently eligible placement **within their own resource home network**. All appropriate Departmental placement requirements must be followed as this transition takes place.
6. RHET will maintain all resource home eligibility documentation electronically using a standardized format for identifying each home (resource home name, agency, date, etc.).

C. Shared Home Agreements

Shared Home Agreements are agreements between a DCS region and a Private Provider for a specific child placement for a specific period of time. Re-classification to a shared home status will not require any additional documentation provided to RHET if it was initially a DCS resource home. If the home was initially a Private Provider home and will remain a Private Provider home when the agreement is ended, then re-evaluation documentation must be submitted to RHET after the resource home's re-approval date.

D. Resource Homes Management

1. Provider Agencies will enter into the Resource Homes Web Application the reason(s) for the termination of homes within their agencies.
2. Provider Agencies will also enter into the Resource Homes Web Application the reason(s) a resource home is requesting a transfer of supervision to another private provider or closure of the resource home.
3. Before a resource home is transferred to new supervising agency, the gaining agency will review the home's most recent application and approval documentation, and meet with the resource parent to ensure the transferring home meets their agency's standards of professionalism.
4. RHET will monitor the termination of homes or transfers to other agencies by a random review of the Web Application System.
5. In the event a resource home is closed, RHET must be notified using the memorandum that is attached as an appendix. Transmission of the memorandum may be by fax (615-532-2263) or by e-mail within two (2) business days of the closure date.

Section V: Required Documentation

As stated previously, RHET will only be concerned with receiving documentation that addresses Federal IV-E requirements. Providers will remain completely responsible for assuring and maintaining all resource home eligibility requirements set forth in DCS policy and contractually agreed upon as per the Provider Policy Manual. Furthermore, the Department will consider a home designated "Approved" by a provider to be a home meeting all DCS requirements for approval. That home will then be considered eligible for placement.

All resource home electronic files maintained by RHET must include the following documents **for both the initial approval process and for the annual re-evaluation process:**

Studies:

- ☐ Provider Resource Home Checklist (signed and dated). If the agency does not have a checklist they may opt to use the sample checklist attached;
- ☐ Home Study (with all required signatures);
- ☐ Annual Re-Evaluation and all applicable IV-E related documentation; and,
- ☐ Home Study Addendums

Background Checks:

- ☐ Local City & County Police Department check;
Note: Local background checks must include the applicant's last five (5) years of residence. Search must also be conducted taking into account current, maiden and any other previous legal names.
- ☐ Felony Offender Registry Check: www.tennesseeanytime.org/foil;
- ☐ National Sex Offender Registry Check: <http://www.nsopr.gov/>;
- ☐ Abuse Registry Check: <http://health.state.tn.us/abuserregistry/index.html>;
- ☐ Sex Offender Registry Check: www.ticic.state.tn.us;
- ☐ Meth Offender Registry Check: <http://www.tennesseeanytime.org/methor>;

- ☐ TN Kids (CPS Person Search) to include Social Services Management System (SSMS) (Initial Home Study only); and,
- ☐ TBI & FBI Fingerprint Checks Results for all household members 18 years of age and older (Initial Home Study only).

NOTE: The above sites are the official sites that are to be used when conducting background checks.

Waivers:

- ☐ Waivers approved by Child Placement & Private Provider (CPPP) Unit on any of the requirements listed.

Training:

- ☐ PATH Completion Certificate (Families who have been approved in the past two [2] years, were closed in good standing, and can provide documentation of PATH completion [or its equivalent i.e. MAPP, PRIDE etc.] will not routinely have to repeat the PATH training requirement.)
- ☐ Child's PATH Participation Certificate (if applicable)

Appendix:

- ☐ **Recommended Provider Checklist (CS-0690)**
- ☐ **Recommended Resource Home Mutual Re-assessment Form (CS-0692)**
- ☐ **RHET Resource Home Closure Notice Memorandum**

AGENCY LETTERHEAD
ADDRESS
PHONE NUMBER

MEMORANDUM

TO: Jim Hartsfield or Anna Wiginton, Resource Home Eligibility Team

FROM: *AGENCY'S NAME/RESOURCE HOME PERSONNEL*

DATE:

SUBJECT: Notice of Closing of Resource Home

Dear RHET:

This letter is to inform you the home of *RESOURCE HOME'S NAME/ID#* will be closed effective *DATE*. This home is closing in *BLANK* standing with *AGENCY'S NAME* for the following reasons:

If further clarification on the closing of this home is desired please contact *NAME* at *NUMBER*.

Sincerely,

Resource Parents Bill of Rights

The Tennessee General Assembly enacted *The Foster Parents Rights Act* in 1997 as an amendment to *Tennessee Code Annotated, Title 37, Chapter 2; Part 4*.

A. Tenets

To the extent not otherwise prohibited by state or federal statute, the department shall, through promulgation of rules in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5, implement each of the following tenets. With respect to the placement of any foster child with a resource parent, that is contracted directly with the department of children's services, pursuant to this part:

1. The department shall treat the resource parent(s) with dignity, respect, trust, and consideration as a primary provider of foster care and a member of the professional team caring for foster children.
2. The department shall provide the resource parent(s) with a clear explanation and understanding of the role of the department and the role of the members of the child's birth family in a child's foster care.
3. The resource parent(s) shall be permitted to continue their own family values and routines.
4. The resource parent(s) shall be provided training and support for the purpose of improving skills in providing daily care and meeting the special needs of the child in foster care.
5. Prior to the placement of a child in foster care, the department shall inform the resource parent(s) of issues relative to the child that may jeopardize the health and safety of the foster family or alter the manner in which foster care should be administered.
6. The department shall provide a means by which the resource parent(s) can contact the department twenty-four (24) hours a day, seven (7) days a week for the purpose of receiving departmental assistance.
7. The department shall provide the resource parent(s) timely, adequate financial reimbursement for the quality and knowledgeable care of a child in foster care, as specified in the plan; provided, that the amount of such financial reimbursement shall, each year, be subject to and restricted by the level of funding specifically allocated for such purpose by the provisions of the general appropriations act.
8. The department shall provide a clear, written explanation of the plan concerning the placement of a child in the resource parent's home. For emergency placements where time does not allow prior preparation of such explanation, the department shall provide

such explanation as it becomes available. This explanation shall include, but is not limited to, all information regarding the child's contact with such child's birth family and

cultural heritage, if so outlined.

9. Prior to placement of the child, the department shall allow the resource parent(s) to review written information concerning the child and allow the resource parent(s) to assist in determining if such child would be a proper placement for the prospective resource family. For emergency placements where time does not allow prior review of such information, the department shall provide information as it becomes available.
10. The department shall permit the resource parent(s) to refuse placement within their home, or to request, upon reasonable notice to the department, the removal of a child from their home for good reason, without threat of reprisal, unless otherwise stipulated by contract or policy.
11. The department shall inform the resource parent(s) of scheduled meetings and staffing concerning the foster child, and the resource parent(s) shall be permitted to actively participate in the case planning and decision-making process regarding the child in foster care. This may include individual service planning meetings, foster care reviews, and individual educational planning meetings.
12. The department shall inform a resource parent(s) of decisions made by the courts or the child welfare agency concerning the child.
13. The department shall solicit the input of a resource parent(s) concerning the plan of services for the child; this input shall be considered in the department's ongoing development of the plan.
14. The department shall permit, through written consent, the ability of the resource parent(s) to communicate with professionals who work with the foster child, including any therapists, physicians, and teachers that work directly with the child.
15. The department shall provide all information regarding the child and the child's family background and health history, in a timely manner to the resource parent(s). The resource parent(s) shall receive additional or necessary information, that is relevant to the care of the child, on an ongoing basis; provided that confidential information received by the resource parents shall be maintained as such by the resource parents, except as necessary to promote or protect the health and welfare of the child.
16. The department shall provide timely, written notification of changes in the case plan or termination of the placement and the reasons for the changes or termination of placement to the resource parent(s), except in the instances of immediate response for

child protective services.

17. The department shall notify the resource parent(s), in a complete manner, of all court hearings. This notification may include, but is not limited to, notice of the date and time of the court hearing, the name of the judge or officer hearing the case, the location of the hearing, and the court docket number of the case. Such notification shall be made upon the department's receipt of this information, or at the same time that notification is issued to birth parents. The resource parent(s) shall be permitted to attend such hearings at the discretion of the court.
18. The department shall provide, upon request by the resource parent(s), information regarding the child's progress after a child leaves foster care. Information provided pursuant to this subsection shall only be provided from information already in possession of the department at the time of the request.
19. The department shall provide the resource parent(s) the training for obtaining support and information concerning a better understanding of the rights and responsibilities of the resource parent(s).
20. The department shall consider the resource parent(s) as the possible first choice permanent parents for the child, who after being in the resource parent's home for twelve (12) months, becomes free for adoption or permanent foster care.
21. The department shall consider the former resource family as a placement option when a foster child who was formerly placed with the resource parent(s) is to be re- entered into foster care.
22. The department shall permit the resource parent(s) a period of respite, free from placement of foster children in the family's home with follow-up contacts by the agency occurring a minimum of every two (2) months. The resource parent(s) shall provide reasonable notice, to be determined in the promulgation of rules, to the department for respite.
23. (Effective February 1, 1998) Child abuse/neglect investigations involving the resource parent(s) shall be investigated pursuant to the department's child protective services policy and procedures. A child protective services family services worker from another area shall be assigned investigative responsibility. Removal of a foster child will be conducted pursuant to Tennessee Code Annotated and departmental policy and procedures. The department shall permit an individual selected by the membership of the Tennessee Foster Care Association to be educated concerning the procedures relevant to investigations of alleged abuse and neglect by the department and the rights of the accused resource parent(s). Upon receiving such training, such individual shall be permitted to serve as advocate for the accused resource parent(s). Such advocate shall

be permitted to be present at all portions of investigations where the accused resource parent(s) are present; and all communication received by such advocate therein shall be strictly confidential. Nothing contained within this item shall be construed to abrogate the provisions of chapter 1 of this title, regarding procedures for investigations of child abuse and neglect and child sexual abuse by the department of children's services and law enforcement agencies.

24. Upon request, the department shall provide the resource parent(s) copies of all information relative to their family and services contained in the personal resource home record.
25. The department shall advise the resource parent(s) of mediation efforts through publication in departmental policy manuals and the *Resource Parent Handbook*. The resource parent(s) may file for mediation efforts in response to any violations of the preceding tenets.

Grievance Procedures

Agencies must develop a process that mirrors the intent of the grievance procedures outlined below.

1. Complaints and Mediation

Any resource parent who determines that the department is in violation of the *Resource Parents Bill of Rights* or otherwise has a complaint should first discuss his/her concerns with the family services worker assigned to the resource home and attempt to work out an agreement. This step may involve showing the resource parent written policy and procedures relative to approval of a resource home or ongoing casework activities. The family services worker must respond to the resource parent's complaint within three (3) working days.

If the family services worker and the resource parent cannot reach an understanding, then the resource parent shall notify the team leader and request assistance from the team leader in mediating the conflict between the family services worker and the resource parent. The team leader must respond to the resource parent's complaint and request for assistance within five (5) working days.

2. Grievances

If the family services worker and the team leader cannot make corrections or adjustments, the resource parent shall notify the team coordinator in writing of their concerns and request an appointment with the team coordinator. A scheduled meeting between all parties with the team coordinator must take place within seven (7) working days of the receipt of the resource parent complaint. The results of this meeting shall be documented in writing within two (2) working days of the meeting; responsibility for the documentation is with the family services worker with approval of the team leader. The

Attachment 5 - Foster Parents Bill of Rights

team coordinator must then make a recommendation in writing for corrective action (or no action). Copies of the team coordinator's decision must be forwarded to all participants.

3. Appeals

Within seven (7) working days of the grievance hearing, the resource parents may elect to file an appeal with the agency director. Upon receipt of an appeal, the regional administrator reviews all the information and either accepts the recommendation of the team coordinator or, at their discretion, may schedule an additional interview with the resource parent(s), DCS staff, and/or other relevant parties. Copies of the regional administrator's approval or modification of the team coordinator's recommendation must be forwarded to all participants.

I. TennCare Services for Children in Custody**A. TennCare Funding for DCS**

The Department of Children's Services receives TennCare funding for two primary services made available through the TennCare/DCS interagency agreement. The services are case management (known as *targeted case management*) and residential treatment services. The per diem funding for contract agency services is provided in whole or in part by TennCare funding depending on the service/level of care.

B. TennCare Services

The overwhelming majority of children entering DCS care will be eligible for TennCare. Exceptions include illegal aliens (however they may qualify to receive emergency care) and children assigned to Youth Development Centers operated by the Department of Children's Services.

Children in detention are eligible for TennCare if not assigned to be transferred to a Youth Development Center.

C. Covered Services

Children in DCS care receive all medical services from the assigned MCO, TennCare Select. Dental care is provided through Doral Dental and pharmacy services are paid by the State of Tennessee through PBM. Behavioral health services are provided by the assigned BHO, Premier Behavioral Health, operated by Advocare. However, children in custody receive residential behavioral services through DCS. TennCare covers all medically necessary EPSDT services. For a resource regarding covered services, refer to "A Quick Guide to TennCare Covered Services" on the TennCare Web site.

D. TennCare Eligibility /Enrollment for Children in Custody

1. When children enter DCS custody, a TennCare Select DCS enrollment form is sent to TennCare Select and the child is enrolled in immediate eligibility. This is to facilitate the initial EPSDT TENNderCare appointment as well as emergent medical needs that may be identified.
2. A Primary Care Provider (PCP) is selected by DCS when the enrollment form is sent. TennCare Select confirms the PCP assignment or assigns a PCP if a preference was not selected.
3. TennCare Select will also verify private insurance information if listed, and verification will be provided when the third party liability unit at

TennCare Select completes this process.

4. The DCS family services worker completes an IV-E/ Medicaid eligibility application, which is provided to the DCS Child Welfare Benefit Worker who determines eligibility for benefits through the Department of Human Services policies and the ACCENT information system.
5. After 45 days, the immediate eligibility expires, and the child is provided a permanent ID card for TennCare services from TennCare Select.
6. The DCS Child Welfare Benefit Worker is responsible for redetermination of eligibility.

E. Initial EPSDT TENNderCare Appointment

(See DCS Policy 20A.7 for periodicity schedule and other details)

1. DCS is required to obtain a TENNderCare EPSDT appointment within the first 30 days that a child enters care. This EPSDT TENNderCare appointment is made at the local county Health Department where the child resides or is placed.
2. By having the Health Department complete the TENNderCare EPSDT screening, the attending nurse may verify that all 7 components of the screening have been completed, as required for the State of Tennessee under a federal court order (*John B. v. Menke*). If the child's Primary Care Provider (PCP) would also like to provide an EPSDT screening due to referrals or to facilitate treatment, the PCP may do this and receive reimbursement from TennCare Select for the service.
3. Contract agency staff are responsible for arranging appointments and working with the DCS family services worker to obtain the following information that must accompany the child to the TENNderCare EPSDT appointment:
 - a. Proof of insurance. TennCare card, 45-day TennCare Immediate Eligibility letter, private insurance card, or *Medical Services Authorization for Certain Non-TennCare Eligible Children* Form CS 0533
 - b. Court custody order
 - c. Immunization record
 - d. *Initial Health Questionnaire*, Form CS 0543
4. The DCS family services worker, foster parent, or contract agency family services worker must accompany the child to the TENNderCare EPSDT appointment.
5. The Health Department sends a letter to the PCP that details the results of the EPSDT screening. The Health Department also provides a copy of this

letter to the DCS Health Advocacy Unit. The regional well-being nurse reviews the letter and notifies the DCS family services worker of the EPSDT results including any needed appointments for referral conditions or follow up recommendations. The Health Advocacy Unit also communicates the EPSDT results and follow-up recommendations to the child's caregiver/placement provider. The SAT (Services and Appeals Tracking) coordinator inputs the information regarding the screening into TNKids/SAT with identified follow up services noted in SAT.

F. Annual EPSDT TENNderCare Screenings

Each child in DCS custody must receive an annual TENNderCare EPSDT screen conducted by the local health department in accordance with the American Academy of Pediatrics periodicity schedule. Children under 24 months of age will be seen on a more frequent basis accordingly.

G. Follow Up EPSDT TENNderCare Services

DCS tracks all identified services in the SAT (Services and Appeals Tracking) to ensure that follow up services are complete. Contract agencies are responsible for ensuring any follow up care identified by the TENNderCare screening is completed in a timely manner. See below (*Health Services Confirmation and Follow Up Form*) for more information about communication to DCS about follow up services provided to the child.

H. Mental Health Assessment

If a child presents with mental health concerns, an appointment for a mental health assessment should be made with a clinician or community mental health center. A mental health concern may be identified in the EPSDT TENNderCare screening or by the CFTM or caregiver. The mental health assessment serves as a more focused EPSDT TENNderCare screening for mental health services, and is an important first step in the determination of mental health service needs. Recommended services should be coordinated with the serving agency.

I. Health Services Confirmation and Follow Up Form

- 1. When a child is taken to receive health services of any kind (including behavioral and dental), the *Health Services Confirmation and Follow Up* form should be given to the clinician with a request that the form be completed or the requested information provided.**
- 2. This completed form or information should be provided to the Regional SAT Coordinator, who will ensure that the information is entered into TNKids/SAT and provided to the DCS family services worker.**

3. The form may be used to provide information to contract agencies, foster parents, and DCS about the services received by children in their care.

J. Access and Advocacy

1. Each DCS Region has a Health Advocacy Unit comprising the following:
 - a. Health Advocate Representative
 - b. SAT (Services and Appeals Tracking) Coordinator
 - c. Nurse
 - d. Psychologist
 - e. Educational Specialist
2. Health Advocacy Units assist family services workers and others serving children in the care of DCS by providing education about EPSDT and health care, and by providing support, intervention, and technical assistance on matters related to TennCare.
3. Health Advocacy Units also make referrals to the Centers of Excellence (COEs) for assessments and for guidance in the development of treatment planning.
4. Provider agencies may contact Health Advocacy Units to coordinate care or for technical assistance.

K. Care Coordination for Children in Custody Receiving Inpatient Psychiatric Services

1. DCS has implemented a process called Psychiatric Acute Care Coordination (PACC) that coordinates the care received by children in custody at acute care psychiatric facilities. The acute care facilities have been provided toll free phone numbers for daytime as well as evenings and weekends to report to DCS any children in custody admitted to hospitals.
2. The hospitals provide basic information to DCS, and DCS provides basic information and contact information to them. DCS contacts the regional nurse, psychologist, child placement division, and family services worker regarding the admission. The nurse coordinates approval of medication and the psychologist works with the hospital on discharge planning.
3. Children admitted for psychiatric care are presumed to be returning to their placement. Agencies should coordinate care with the acute facility and DCS, ensure that the child has clothing, and that persons authorized to visit are provided information about visitation. Agencies should coordinate with the DCS family services worker and health advocacy team as needed.

L. Coordinating Health Care When a Child Has Private Insurance

When a child has private insurance, the other insurance benefits must be coordinated with TennCare. TennCare is the “payor of last resort;” other insurance is primary to TennCare. It is best if the child accesses a PCP or other provider that takes both the primary insurance and TennCare Select. If this is not possible, it is necessary to go to the primary carrier’s provider. That provider must bill TennCare for the difference in any payment, equal to what TennCare Select would have paid.

M. DCS Covered Services (Permanency and Reasonable Efforts)

1. The following services can be authorized through regional fiscal team funds for children in, or at risk of, custody:
 - a. Services to promote permanency identified by the CFTM
 - b. Prevention and intervention services
 - c. Services to families that advance reasonable efforts
 - d. Transportation cost for children and families
 - e. Medical and behavioral health services (when the child is not TennCare-eligible or the service is not covered by TennCare)
 - f. Copays for children in custody who have private insurance
2. The following standard prevention/intervention services are available:
 - a. Alcohol and drug testing services
 - b. Child care and sitter services
 - c. Emergency placement
 - d. Emergency purchases
 - e. Family support
 - f. Family violence intervention
 - g. Homemaker services
3. Examples of services to promote permanency include:
 - a. Transportation for a parent to AA or NA meetings
 - b. Babysitting fees for a foster parent
 - c. Homemaker services for a parent with challenging children
4. Examples of standard services to promote permanency include:
 - a. Independent living services
 - b. Adoption support services
 - c. Child care and sitter services
 - d. Emergency purchases
 - e. Family support

See service definitions at the end of this document.
5. There is not a comprehensive list of the above services because there are no exact answers regarding coverage for a particular family or child in a

specific effort toward reunification, or permanency, well-being or safety. Rather, clinical judgment should be part of the process in providing services to children and families. For instance, the following kinds of questions should be asked in the process of making an appropriate decision making regarding services:

- a. Can providing the service prevent custody?
 - b. Does provision of the service support reasonable efforts by the department to meet the needs of the child or family?
 - c. What will it take to bring about permanency in this situation?
6. Services should be discussed at the child and family team meeting. The DCS family services worker will pursue recommendations for services with the DCS regional fiscal team.
 7. When there are clinical decisions, response to questions about DCS reimbursement will be made through regional leadership, including the regional administrator, clinical supports, and the fiscal team.

II. Child and Family Team Meetings: Permanency Planning

Decision of Level II/III/IV Services

Notice Provisions

A. Child and Family Team Meetings

1. As set forth DCS policy, child and family team meetings are the primary decision-making and case-planning tool used by all case management staff.
2. Child and family team meetings are held for the purposes of developing the permanency plan. (See DCS Policy 31.7) Within fifteen (15) working days of the child's entry into state custody, a CFTM shall be held for the purposes of developing the permanency plan. The permanency planning CFTM should build upon the work done in the initial CFTM with the family.

B. Placement Decisions

1. Child and family team meetings (CFTM) are held to determine service needs for children in DCS custody, including placement. The placement may be residential care that is a DCS-administered TennCare covered service.
2. Residential services that are DCS-administered TennCare services are Level II/III/IV residential or continuum services, as follows:
 - a. Foster Care Medically Fragile
 - b. Foster Care Therapeutic
 - c. Level II
 - d. Level II Continuum

- e. Level II Special Needs
- f. Level II Special Population
- g. Level III
- h. Level III Continuum
- i. Level III Continuum Special Needs
- j. Level IV
- k. Level IV Special Needs

C. CFTM Attendance for Placement Decisions

When a placement decision will be discussed, the following persons must be invited to attend the CFTM:

- a. Child if 12 or older
- b. Biological parent (s) *if no TPR*
- c. Guardian
- d. Skilled and trained facilitator
- e. Resource parent
- f. Child's attorney or guardian ad litem (GAL)
- g. Residential service provider.

Note: *Any member of the child and family team may initiate a CFTM to address an issue or concern that has arisen. The purpose of the CFTM is to pull together only those members of the team necessary to address the concern(s). (Policy 31.7) The child and/or family should be encouraged to bring an advocate or internal supports.*

D. Notice of Action Regarding TennCare Services

- 1. A Notice of Action (NOA) setting forth the determination regarding placement must be provided to each of the persons indicated above where a placement determination is discussed.
- 2. The facilitator of the CFTM shall provide to all participants of the CFTM a copy of the template *Notice of Action* (NOA), with the *TennCare Appeal* form attachment, at any CFTM when placement services are discussed.
- 3. The facilitator must inform the participants that they have the right to appeal a determination made about a residential service. The facilitator must inform the participants that a completed Notice of Action (NOA) specific to the determination made in the CFTM will be provided to them after the meeting. The facilitator should make sure that addresses of all participants are obtained and provided to family services workers for entry into TNKids to ensure that the notice of action can be sent following the CFTM.

E. Entry of Placement Determination in TNKids

Following the CFTM, the family services worker must complete the Review/CFTM in TNKids within two (2) business days. If the system detects that the LOC value recorded on this review meets the criteria for a Notice of Notion (NOA), the system will generate one. The family services worker will receive an NOA to complete.

F. Notice of Action to Participants

After completion and printing of the NOA, the NOA must be mailed to the participants/recipients on the NOA.

G. Notice of Action to TennCare Consumer Advocates

1. Special Grier provisions require that notices be provided to TennCare Consumer Advocates to review and determine whether appeals should be filed on behalf of children to ensure the timely receipt of TennCare services.
2. Following the initial CFTM, a copy of the child's permanency plan and a notice of action will be faxed or mailed to the advocacy contractor within two (2) days of the staffing.

H. Appointments and Services

1. Following the CFTM, appointments for identified services must be made in a timely manner. The family services worker ensures that appointments for the identified TennCare services are made within two weeks of the CFTM meeting. The family services worker **or** the provider agency notifies the SAT when appointments are arranged.
2. The contract agency, family services worker, or foster parent provides the *Health Services Confirmation and Follow Up* form to the provider rendering the TennCare MCO or BHO service to report services provided and whether follow up services are indicated.
3. The completed *Health Services Confirmation and Follow Up* form needs to be provided to the SAT Coordinator.

I. Additional CFTMs

If, following a CFTM, additional services are requested or concerns are identified regarding the child's level of service, the DCS family services worker will arrange for a subsequent staffing to be held within ten (10) working days.

J. Urgently Needed Services

If an individual requests a service on behalf of a DCS child that requires a prompt response in light of the child's condition and urgency of need, as defined by a prudent layperson, and, under the circumstances, there is not sufficient time to hold a staffing, then the child's caseworker shall promptly respond to the individual's

request without holding a staffing. If DCS denies the requested service then a *Notice of Action* shall be mailed to the child/youth (age 14 or older), parent, guardian, foster parent, child's attorney or guardian ad litem (GAL), the Advocacy Contractor, provider, and other advocate within two (2) days of responding to the individual's request.

Note: *This is not intended to replace or affect provider manual policy requirements regarding disruption staffings for DCS contracted providers.*

III. Deauthorization of TennCare Funded Services

In the event that a CFTM is not held and the resource management unit deauthorizes a DCS-administered TennCare service, a *Notice of Action* setting forth the following must be sent a minimum of ten (10) days prior to the action: the date the service will be reduced or discontinued (e.g., suspended, terminated), the type and number of services at issue, and a statement of reasons for the proposed action.

A. Discontinuation of TennCare Services

In the event that a CFTM is not held and DCS otherwise denies or discontinues a DCS-administered TennCare service, a *Notice of Action* setting forth the nature of the adverse action, the type and number of services at issue, and a statement of reasons for the proposed action must be provided to those individuals listed in Item 2 a minimum of ten (10) days prior to the action.

B. Continuum Provider Notice Provisions

When continuum providers reduce, delay, or suspend services to children/youth who are transitioning to home, who have been at home, or who are otherwise no longer in custody, a *Notice of Action* and *TennCare Medical Care Appeal* form shall be mailed by the continuum provider to the DCS family services worker, the involved adult, and the advocacy contractor. Continuum providers shall mail a *Notice of Action* and *TennCare Medical Care Appeal* form to the child/youth's physical guardian a minimum of ten (10) days prior to discontinuing services to a child/youth who is no longer in physical custody.

C. Right to Appeal

Those receiving a *Notice of Action* may appeal the action by filing a *TennCare Medical Care Appeal* form, which will be sent to the TennCare Solutions Team. Appeals must be made to the TennCare Solutions unit within thirty (30) days of the notice to deny, delay, reduce, suspend, or discontinue services.

D. Grier Appeals Process

1. Following the initial CFTM, a copy of the child's permanency plan and a

Notice of Action will be faxed or mailed to the advocacy contractor within two (2) days of the staffing.

2. Following all subsequent CFTMs, a copy of the *Notice of Action* will be faxed or mailed to the advocacy contractor within two (2) days of the CFTM, unless the permanency plan has been revised, in which case the advocacy contractor will additionally be faxed or mailed a copy of the revised permanency plan.
3. Under the TennCare agreement and Grier provisions, the Advocacy Contractor will conduct a substantive review of procedures followed and services rendered, and will monitor implementation of the determined services and may file an appeal as needed to effectuate the rights of the child.

E. Special Provisions for Continuum Contractors

1. Continuum providers shall mail monthly treatment reports within five (5) days of completion, with a *Notice of Action* and *TennCare Medical Care Appeal* Form, to the DCS family services worker, an involved adult, and the advocacy contractor.
2. Continuum providers shall mail or fax *Type A Incident Reports*, within forty-eight (48) hours of the incident, with a *Notice of Action* and *TennCare Medical Care Appeal* form, to the DCS family services worker, an involved adult, and the advocacy contractor.

(This policy does not otherwise alter DCS policy regarding disruption staffings.)

F. Appeal Rights

A TennCare enrollee may appeal any adverse action, generally indicated as the denial, delay, reduction, suspension, or discontinuation of a service. The Notice of Rights provided by DCS for the DCS TennCare administered services (Level II/III/IV) gives the enrollee (the child) notification of this right. The TennCare consumer advocacy contractor may also appeal on behalf of a child.

G. Appeals Process Overview

1. When an appeal is made, the appeal is processed by the Bureau of TennCare, TennCare Solutions. An appeal is processed as a standard appeal unless the enrollee files the appeal as urgent (or expedited).
2. For all appeals, TennCare Solutions notifies the MCC (managed care company) that an appeal was received on a service provided by the MCC, and informs the MCC that a response is due in 14 days for a standard appeal, and 5 days in the event of an expedited appeal.

3. For medical, dental, and behavioral health services, the responsible MCC is responding to whether they agree that the service should be provided. Generally there has been a denial or delay by the MCC prior to the appeal and the MCC provides a reconsideration response either upholding its original decision or changing its original decision and providing the service.
4. For DCS administered TennCare services, the reconsideration response is generally regarding services that DCS has already determined the enrollee needs. DCS provides two (2) TennCare funded services: residential services (levels 2/3/4) and targeted case management services. Targeted case management includes making appointments to arrange for services, arranging transportation, and making appointments or other arrangements to see that follow up or recommended services are provided to the child.

H. DCS Reconsideration

1. For appeals regarding DCS services, the TennCare Solutions division sends the Request for Reconsideration to the DCS regional health advocacy representative or other person designated to respond on behalf of the regional administrator.
2. The reconsideration response should contain specific information regarding whether the residential services have/have not been received. If the residential service has been arranged, proof of this on letterhead from the DCS contract agency or other entity should be provided. If the appeal is in regard to other services arranged by DCS through targeted case management, information on the appointment/arrangements should be provided. If the service requested to be arranged has not been prescribed by a health or mental health professional, an appointment with a mental health clinician or a primary care provider should be made to facilitate a determination of services needed and to be prescribed.
3. Upon completion of the reconsideration response, the health advocacy representative or other designee should provide copies to the regional administrator, team leader, and family services worker. The health advocacy representative or other designee should obtain technical assistance from Central Office Health Advocacy as needed in responding to appeals.
4. When appeals are in regard to Level II/III/IV residential services, the health advocate representative should notify regional resource management, who should obtain technical assistance from Central office Child Placement as needed in making arrangements and in responding to appeals.
5. The TennCare Solutions team shall review the decision of the health advocacy representative or other designee for the regional administrator. The TennCare Solutions unit will review the information and do one of the following:

- a. Issue an informal resolution, closing the case. In this instance, the service has been provided and there is not an outstanding service.
- b. Issue a directive that a service, or confirmation of a service, be provided. Directives are issued to the Commissioner of the Department of Children's Services.
- c. Issue a notice that the service is not to be provided. In this instance, the appeal is forwarded to the Office of General Counsel for the Bureau of TennCare, as the enrollee is entitled to a hearing on the matter of whether the service should be provided.

I. Legal Counsel for Children in Care

1. DCS maintains a contract for the provision of legal services related to TennCare appeals for custodial children. Legal services are provided related to the resolution or preparation of a hearing resulting from a TennCare Appeal. DCS must refer the following to the legal contractor within 48 hours of the appeal notice:
 - a. All expedited appeals
 - b. All appeals forwarded to the Office of General Counsel for the Bureau of TennCare for hearing.
2. The legal contractor may request any additional assessment information as needed to provide legal representation and to otherwise safeguard the rights of the child/youth. DCS employees shall reasonably cooperate with the legal contractor in providing records and testimony as needed.

J. Continuation of Services During Appeals

1. If an appeal regarding a change in a child's/youth's level of care is made within ten (10) days of the staffing, the change in services shall not be implemented until the appeal is resolved unless, in the opinion of the DCS consulting medical director, delaying the change in level of service is medically contraindicated.
2. If at any staffing a higher level of service is determined to be needed and an appeal is received requesting a lower level of service, the service of the higher level will be implemented and provided until the appeal is resolved.
3. If an appeal is received from a DCS contracted provider requesting a continuation of stay for residential care, and all other interested parties have determined that the child should go to a different level of care or have the services discontinued, DCS will have its consulting medical director review the case. If the consulting medical director certifies the child's treatment needs will not be jeopardized, the proposed transfer may continue and DCS will authorize an attorney to represent the child at the administrative hearing. Services will be reinstated if determined to be medically necessary and in the

best interest of the child.

Note: *Nothing in this paragraph supersedes the child's right to refuse services.*

IV. Advocacy for TennCare Health Services

A. Filing Appeals for Children in Custody

1. TennCare provides all medically necessary services for children. These services are administered through the Managed Care companies, and included medical, behavioral, pharmacy, and dental services.
2. DCS family services workers and staff may obtain specific information about accessing services through TennCare on the DCS intranet under the TennCare section of Frequently Asked Questions (FAQ). DCS family services workers and staff may receive technical assistance from Health Advocacy units, based in each region. Contact information for well-being units is also found at the FAQ intranet TennCare site.
3. When a TennCare managed care company denies, reduces, suspends, terminates, or discontinues a TennCare service, a written notice should be provided. For children in DCS custody, these TennCare notices of adverse action should be sent to the Central Office Health Advocacy division. However, they may be mailed to the DCS family services worker (the child's address on the TennCare enrollment file).
4. If the DCS family services worker does receive a written notice of adverse action, the DCS family services worker must immediately provide a copy to the regional health advocate representative, in the health advocacy unit. The health advocacy representative will file an appeal with the TennCare Solutions unit at the Bureau of TennCare.
5. When a DCS family services worker or other DCS staff encounters any barriers accessing a TennCare service for a child, they should contact the health advocacy unit. An appeal will be filed with the TennCare Solutions unit at the Bureau of TennCare when any prescribed service is denied, delayed, reduced suspended or discontinued.
6. DCS provider agencies should notify the DCS family services worker, or in the alternative the health advocacy unit, should they receive any notice of adverse action, or encounter barriers accessing a TennCare service for a child.

B. Retaliatory Actions Prohibited

Individuals involved with children/youth in care are encouraged to exercise their right to appeal. DCS employees are strictly prohibited, under any circumstances, from taking any action or threatening to take any action whatsoever against an individual based upon that individual's filing of an appeal.

C. Non-TennCare Permanency Issues

The family services worker shall resolve permanency plan issues that do not pertain to DCS-administered TennCare services. If the family services worker cannot resolve these issues, the family services worker's supervisor may become involved. If these issues cannot be resolved by discussions with the family services worker or supervisor, they may be brought to the attention of the foster care review board or before the court.

- ☐ **Pre-service Training Requirements** (Must be completed before child placement.)
DCS Policy 16.4 Resource Home Approval

Standard Resource	30 hours of PATH +4 hours Med Ad +4 hours CPR+4 hours First Aid = 42 hours
Medically Fragile	All of the above for Standard Resource + 15 hours of specialized training for medically fragile
Therapeutic	All of the above for Standard Resource + 15 hours of specialized training using a Therapeutic Curriculum
Juvenile Justice	All of the above for Standard Resource + 9 hours of specialized juvenile justice training

- ☐ **First Year Training Requirement** (15 hours) must be completed within first year after approval date. All resource home parents must complete the 15 hours of core training on topics as listed in DCS Policy 16.8, Responsibilities of Approved Resource Homes.

- ☐ **In-service Training Requirements** (After the first year, hours must be completed every year by anniversary of approval date.) DCS Policy 16.8 Responsibilities of Resource Parents

Standard Resource	15 hours
Medically Fragile	15 hours
Therapeutic	15 hours
Juvenile Justice	15 hours

LICENSURE MATRIX

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The following is a list of residential program settings licensed to serve children and youth within the State of Tennessee. This list is simply a guideline provided to assist you in determining the correct license type for your program. Please note it is the responsibility of each vendor to coordinate with the appropriate licensing entity to ensure proper licensing is obtained for each program site; including sub-contracted sites. Verification of appropriate licensing must be submitted prior to contract.

Please contact the following offices with any questions regarding licensing requirements:

DCS Division of Licensing Mark Anderson, Director (615) 532-5640

MHDD Office of Licensure Amber Gallina, Director (615) 532-6590

Setting	Type of License/Link to Standards	Licensing Agency	Approved School Site
Residential Program serving 1-6 children (Non-Mental Health)	Family Boarding Home http://www.state.tn.us/sos/rules/0250/0250-04/0250-04-02.pdf	DCS	
Residential Program serving 7-12 children (Non-Mental Health)	Group Care Home http://www.state.tn.us/sos/rules/0250/0250-04/0250-04-02.pdf	DCS	
Residential Program utilizing individual resource homes and/or any combination of Group Care Homes and Family Boarding Homes	Child Placing Agency http://www.state.tn.us/sos/rules/0250/0250-04/0250-04-09.pdf	DCS	
Residential Program serving 13 or more children (Non-Mental Health). Applies also to smaller programs on contiguous properties where total combined population exceeds 12	Residential Child Care Agency http://www.state.tn.us/sos/rules/0250/0250-04/0250-04-05.pdf	DCS	
Any residential program serving more than 1 pregnant youth (may be a supplemental license)	Maternity Home http://www.state.tn.us/sos/rules/0250/0250-04/0250-04-07.pdf	DCS	
Juvenile Detention Center	Juvenile Detention Center http://www.state.tn.us/sos/rules/1400/1400-03.pdf	DCS	
Mental Health Residential Treatment Program (Non-Hospital Setting)	Residential Treatment Facility http://www.state.tn.us/sos/rules/0940/0940-05/0940-05-37.pdf	MHDD	
Mental Health Residential Treatment Program (Hospital Classification)	Mental Health Hospital Facility http://www.state.tn.us/sos/rules/0940/0940-05/0940-05-16.pdf	MHDD	
Alcohol and Drug Treatment Facility	Residential Rehabilitation Treatment Facility http://www.state.tn.us/sos/rules/0940/0940-05/0940-05-45.pdf	MHDD	
Residential Program serving MR students in a community setting	Mental Retardation Residential Habilitation Facility http://www.state.tn.us/sos/rules/0940/0940-05/0940-05-24.pdf	MHDD	

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DCS Policy 21.14 Serving the Educational Needs of the Child/Youth

<http://www.tennessee.gov/youth/dcsguide/policies/chap21/21.14%20Serving%20the%20Education%20Needs%20of%20the%20Child-Youth.pdf>

DCS Policy 21.16 Rights of Foster Child with Disabilities and IDEA

<http://www.tennessee.gov/youth/dcsguide/policies/chap21/21.16%20Rights%20of%20Foster%20Child%20with%20Disabilities%20and%20IDEA.pdf>

DCS Policy 21.18 Notification to School Principals of Certain Delinquency Adjudications

<http://www.tennessee.gov/youth/dcsguide/policies/chap21/21.18%20Notification%20to%20School%20Principals%20of%20Certain%20Delinquency%20Adjudications.pdf>

DCS Policy : 21.20 Non-traditional Educational Settings

<http://www.tennessee.gov/youth/dcsguide/policies/chap21/21.20NonTraditionalSchoolSettings.pdf>

Standards 6-400 through 6-409

1. Needs Assessment

The provider will ensure that the educational needs of students are thoroughly assessed.

Commentary. The provider will obtain and review previous educational records for each student. Children who require special educational services must be identified, and the agency must ensure that those services are provided.

For agencies with in-house schools:

- a. Upon enrollment, an academic assessment shall be administered that measures (at a minimum) math, reading, and written expression skills if current (within one-year) testing is not available.
- b. A vocational assessment shall be administered to any student at least 14 years of age who has not been previously assessed.

2. Enrollment in Local Schools Systems

The provider will ensure that children and youth will be enrolled in the local school system rather than an in-house school as defined in departmental policy (DCS Policy 21.14).

Commentary. There is a presumption that children in state custody should be educated in the public schools whenever possible. Children and youth who have an identified and documented treatment need that prohibits placement in public school may attend an in-house educational program in a contracted treatment center for a short period of time. Regular reviews of the students'

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progress should be conducted so that they may return to public school at the appropriate time.

- a. Agency Case Management/Agency School Liaisons' Responsibilities
 1. Agencies with group homes or residential treatment centers shall appoint local staff member to act as "school liaison." The agency school liaison will work to develop a collaborative relationship with the public school system to assist children/youth in maintaining positive and successful school experiences. The school liaison must be available during the school day to respond to public school inquiries.
 2. Upon being assigned to the child/youth's case, the agency case manager (foster care) or agency school liaison (group homes or residential treatment centers) in coordination with the DCS FSW will contact the receiving public school system to determine what educational records are necessary to enroll the child and then immediately begin the enrollment process. The DCS home county family services worker will provide the Education Passport to the agency case manager/school liaison. The agency shall forward any school records received from public or private school, home school, or that the agency generates within their in-house school to the FSW. Providers are to maintain a copy of the passport in the agency files and ensure that the resource parent also has a copy of the Educational Passport.
 3. The agency case manager/school liaison in coordination with the DCS FSW shall prepare a form letter (see DCS form School Enrollment Letter as a guide) to the public school identifying the resource parents and providing basic information about the child/youth to the school. A copy of the form letter will be given to the resource parents if applicable, along with copies of the child/youth's Education Passport.
 4. The agency case manager/school liaison in conjunction with the DCS FSW shall ensure that the child/youth is registered in school and the resource parents have all the necessary information and documentation to facilitate the registration process (the Education Passport).
 5. The agency case manager/school liaison or resource parents may enroll the child/youth in public school, whichever is decided to be in the child's best interest and will address the child's educational needs. The agency case manager/school liaison will coordinate

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with the DCS FSW and will confirm that school enrollment has taken place and will monitor and provide ongoing liaison services with the school. The resource parents will be considered as the primary contacts on a day-to-day basis. The agency case manager/school liaison in conjunction with the DCS FSW will have the ultimate responsibility for the child/youth's educational needs.

6. If the child/youth is determined to have special education needs and/or significant discipline problems, the agency case manager/school liaison in coordination with the DCS FSW will immediately notify the DCS regional education specialist to inform him/her of those needs.
7. If the child/youth appears unlikely or has proven unable to function in public school, the agency case manager/school liaison will coordinate with the DCS FSW and shall immediately notify the regional DCS education specialist. The DCS education specialist will work jointly with the agency case manager parents, resource parents, surrogate parents, and others as necessary to determine educational support and recommendations.
8. Education goals must be included in the agency's plan for the child/youth. Goals must be written to ensure that the child/youth receives educational benefits while in the care of the agency.
9. The agency case manager/school liaison will coordinate with the ESW and ensure that a DCS representative is in attendance at all IEP meetings. The DCS education specialist and/or DCS education attorney may be included as appropriate and necessary. The resource parents will attend IEP meetings, if possible. The DCS education attorney will assist with disciplinary issues and negotiations with the local school system regarding the obligations of the school system. The Well-Being Unit staff may be able to identify additional resources.
10. If a child/youth faces serious disciplinary action, the agency case manager/school liaison must contact the DCS regional education specialist or DCS education attorney for assistance.
11. The agency will use clinical experts and other student support services to work with students, school personnel, and other members of the school community to enable a child's success in school.
12. When the agency is notified that a child/youth is having behavioral problems at home and/or school significant enough to cause a

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future disruption of the child/youth's placement, the case manager must contact the DCS Well-Being Unit immediately requesting assistance in obtaining in-home wraparound services for the child/youth and resource family.

13. The agency maintains an education file separate from the clinical treatment file. This file must contain regular case manager communication with the resource parent and school social worker/counselor/staff, as appropriate, and document in the child's file the child's educational progress.
14. The child/youth remains in his/her former school, if possible.

3. Suspension/Expulsion from Public School

DCS is committed to ensure all custodial children receive educational services and continue with their pre-custodial educational goals. It is the responsibility of all involved parties to support each child's school placement and educational plan.

- a. In the rare instance that a child/youth has been excluded from public school and cannot be readmitted in another public school setting (such as in zero-tolerance instances), a CFTM shall be convened within but no later than five (5) calendar days and **must** include the regional DCS education specialist. At this meeting, alternative education arrangements shall be developed for the child. This will include delegation of case management tasks and a fiscal plan to ensure payment for all educational services.
- b. If the child receives special education services or Section 504 accommodations and is suspended for 10 or more days, notify and involve the regional DCS education specialist.
- c. If the child/youth is moved to another placement location without the convening and/or the consensus of the CFTM, DCS shall not reimburse the provider for the costs of the educational arrangement (if applicable) until a CFTM is held and consensus is achieved.
- d. The agency will document all contacts to the FSW to request a CFTM. Documentation will be copies of faxed or emailed requests.

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4. Provider Agency and DCS In-house Schools

DCS Policy 21.20 Non-traditional Educational Settings.

<http://www.tennessee.gov/youth/dcsguide/policies/chap21/21.20NonTraditionalSchoolSettings.pdf>

a. Determination of placement

The child/youth's treatment plan must document treatment needs that would interfere with public school attendance. The following reasons are some examples of why a child/youth would be unable to attend public school and consequently need to be served in an in-house school:

1. current identified alcohol and drug treatment issues that require a self-contained treatment program;
2. identified sexual offending treatment issues that require a self-contained program;
3. zero-tolerance issues that prohibit enrollment despite involvement and efforts of the educational specialist and/or the DCS attorney;
4. placement in wilderness programs in which the treatment regime is so integrally related to the educational program that attendance at public school would disrupt treatment;
5. a crisis requiring intensive supervision due to community or child-safety treatment needs, or a crisis such that the child is at imminent risk of disruption of placement; or
6. public school placement would cause the youth to lose academic credits (such determination will be made through a CFTM and will include a best interest of the child analysis).

b. Procedures for in-house school attendance

1. If the child/youth requires an in-house educational program, the child/youth may be in that educational setting up to thirty (30) total days.
2. Prior to the end of the thirty (30) day limit, the agency where the child is attending school must contact the child's educational specialist to convene a staffing. The staffing may include the DCS family services worker, agency

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representative(s), the resource parents, any individual with educational rights, a DCS attorney, a Well-Being Unit staff member, and other professionals as necessary and appropriate. In-house school staff must invite a representative from the local education agency. A target date for into public school will be established. The DCS staffing team will have the responsibility for reviewing the child's progress in order to enroll the child in public school at the earliest possible date.

3. During the staffing, a consensus should be reached regarding the educational services that would best meet the needs of the child/youth and his/her treatment plan. If the consensus indicates that the child/youth should continue to receive services at an in-house school or other alternative to public school, the treatment team will establish the specific treatment issues that require the child/youth to be in the in-house school and provide a review and target date for completion of the treatment and projected date for transition to public school. The reasons for such placement and the goals of such educational services must be included in the documentation along with an expected duration or time frame.
4. If no consensus regarding the most appropriate educational setting is reached during the staffing, the FSW and the education specialist will, within three (3) days of the meeting, present the case directly to the regional administrator for a decision. NOTE: When a child is being considered for placement in public school, the CFTM should determine if the child has any of the adjudications listed in DCS Policy 21.18 that would require a notification to the public school. The CFTM should consult the regional education specialist before placing any student with these adjudications in public school.

5. Alternative Education Placements

- a. The following categories of youths may be eligible for approval of an exception to public school attendance so that they can be enrolled in alternative education programs:
 1. youth aged 17 and up who are eligible and for whom it is

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- appropriate to take the GED;
 - 2. youth eligible for and desiring enrollment in vocational or journeyman training; and
 - 3. youth who have graduated from high school or achieved a GED.
- b. Home schooling may be another alternative. Generally, home schooling of children/youth in state custody is appropriate only under certain situations and may occur only with the permission of the DCS Director of Education. FSWs shall notify the regional Educational Specialist when home schooling is being considered by a Child and Family Team.
 - 1. a CFTM has determined that it is in the best interest of the child (there is no requirement for the provision of special education services in home schools);
 - 2. educational progress is monitored and documented as defined by a CFTM (an exception to required documentation would be during trial home visits); or
 - 3. the FSW notifies and involves the regional educational specialist.

6. Education Plan for Children Placed Temporarily

Determining the education setting for the child/youth in temporary, emergency type placements (DCS and agency foster homes):

- a. If the child/youth is in a temporary, emergency type of placement, it is the department's expectation that the child/youth remain in his/her former school if doing so is in the child's best interest. The local school system is obligated to provide transportation for children falling within the McKinney-Vento Homeless Education Act of 2001. The DCS family services worker, in consultation with any involved agency family services worker, will:
 - 1. advocate for enrollment, transportation (if needed), and other services under McKinney-Vento for those DCS children who are McKinney-Vento eligible;
 - 2. utilize the public school system's McKinney-Vento liaison;
 - 3. seek help from the regional education specialist or DCS attorney if needed;
 - 4. collaborate with school systems and contract providers

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regarding transportation to ease the burden on the involved school system(s) where feasible; and

5. in the event of a dispute with the school, request that the resource parent transport the child back and forth to school until his/her placement is made in a more permanent setting. (If the resource parent is unable for legitimate reasons to transport the student, DCS will provide an alternative.)

7. Emergency Shelters/Primary Treatment Centers (PTC)

- a. If a child/youth is placed in an emergency shelter or a PTC, attempts should be made to keep him/her in his/her former school if doing so is in the child's best interest. The CFTM will determine the child's best interest regarding school placement location.
- b. If a child/youth is placed in an emergency shelter and is not able to attend public school, this time period (30 days for a shelter) must be used as an educational assessment period by the agency. The agency's staff in conjunction with the school liaison will develop an education plan to allow the child/youth to complete remedial or ongoing schoolwork during the remainder of his/her stay.
- c. At the end of the placement in the emergency shelter, agency staff and DCS education staff will provide to the DCS family services worker any recommendations for future evaluations and educational programs.

8. In-house School Enrollment

When circumstances require student enrollment in an in-house school, the provider will ensure that the educational program is substantially similar to that provided to other students in the school district.

Commentary. Students in contracted in-house schools must be able to continue to make progress toward graduation with a GED, a regular diploma, a diploma of specialized education, or a high school certificate. In order to do so, the contracted in-house school must provide an educational program that is approved by the Tennessee State Department of Education (DOE) and is recognized by DCS to offer educational services to students in its custody. Each year agencies providing in-house schools will complete an In-House School Proposal. This proposal will document the school's compliance with specified educational standards. These standards include, but are not limited to, the following:

- a. All in-house schools will be approved by the Tennessee State

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Department of Education (DOE) as Category I, II, or III, VII.

- b. All teachers will be qualified according to state requirements, and at least one full-time special educator shall be among the teaching staff.
- c. Direct service providers in the on-grounds school will have (a) educational and experiential backgrounds that enable them to participate in the overall treatment program and to meet the emotional and developmental needs of the children served; and (b) personal characteristics and temperament suitable for working with children with special needs.
- d. Educational personnel will facilitate school transfers and provide consultation as needed to professionals in off-campus educational settings.
- e. Educational plans will be developed for each student and will be coordinated in a manner that maximizes the impact on his/her educational and treatment goals.
- f. The agency will identify a public school liaison and a process for interaction with the public schools focusing on the development of good relationships and effective communication with the local school system.
- g. Educational texts and curriculum materials shall be current, state approved, and rotated at regular intervals.
- h. The organization will provide students with an educational program designed to lead to a Tennessee high school diploma or General Equivalency Diploma (GED).
- i. The organization will provide or arrange as necessary tutoring, mentoring, and college preparation.
- j. The school will provide (a) a 6.5-hour school day as required by the Tennessee State Department of Education, and (b) a school schedule that will allow a high school student to earn at least five (5) credits during a given school year.
- k. Teachers in the on-grounds school will receive a minimum of thirty (30) hours per year of approved in-service activities as required by the Tennessee Department of Education.
- l. Teachers in the on-grounds school will be evaluated using the Framework for Evaluation and Professional Growth as required by

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the Tennessee State Department of Education in order for teachers to maintain licensure.

- m. Students will be provided access to computers and library/research materials comparable to those provided to students in public schools.
- n. The on-grounds school will provide a summer school program that includes an academic component.
- o. The agency and on-grounds school will provide special education and related services for individual students as required by the Individuals with Disabilities Education Act (IDEA) and the state of Tennessee. For example, the facility and programs will be accessible to students with disabilities; students will be screened upon entry at the agency to determine if they are eligible for special education services; psycho-educational evaluations will be conducted within legal timelines; instructional and related services will be provided to eligible students by appropriately licensed special educators; child-find procedures will be implemented; and trained surrogate parents will be assigned when necessary.
- p. Documentation as to compliance with Standards 6-401 and 6-404 will be provided in the in-house school proposal.

Throughout the year, regional educational specialists will conduct monitoring visits at the in-house schools and will file reports with the DCS Education Division. If noncompliance with any of these standards is indicated, the provider will be requested to take immediate steps to correct the deficiency. Failure to address the deficiency may result in an in-house school not being allowed to educate DCS students.

9. Parental Involvement in Educational Planning

The provider will ensure that parents/guardians are involved in the educational planning and educational activities of students.

Commentary. Unless the court has terminated parental rights, a student's parents are to be involved in the planning of the child's education program. This is a "best practice" since reunification is often the goal for students in custody. In addition, both federal and state law require parents to be invited by the school to participate in meetings for students eligible to receive special education services.

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10. Availability of Educational Staff and Attorneys

The provider will ensure that educational staff and attorneys are available to assist case management staff in advocating on behalf of students in state custody.

Commentary. Each DCS region has been assigned an educational specialist and an educational attorney to advocate for students in state custody. The educational specialists should be the first contact for agencies that need assistance with any part of a student's educational program. The educational specialists will work in conjunction with the DCS Education Office to ensure that appropriate educational services are provided to all students in custody. As necessary, the educational attorney shall assist students, agencies, and other DCS educational staff with legal issues surrounding the student's instructional program.

- a. Each resource parent is required to have two (2) hours of in-service training per year on education services/issues for the child/youth in DCS custody.
- b. Each agency family services worker/DCS family services worker/agency school liaison working in the area of foster care is also required to have two (2) hours of in-service training per year on educational services/issues.
- c. Training may be made available through the regional training coordinators and the DCS regional education specialists and DCS education attorneys.
- d. For recurring public school discipline problems (10 days or more in one school year), the regional DCS education specialist or DCS education attorney should be contacted for assistance.

12. Enabling Success in School

The provider will use clinical experts and other student support providers to work with students, their families, school personnel, and all other members of the school community to enable a child's success in school.

Commentary. Many students in custody in DCS schools or contracted in-house schools have needs that require them to see professional clinicians (or other support providers) in order to make progress toward returning home and attending public schools. Since students spend a great deal of time in school, staff should understand the needs of students, should have assistance in handling these needs, and should realize that these needs will likely manifest themselves in the classroom. Both students and staff should have access to trained professionals and

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other support staff to help them deal with difficult issues.

13. Supporting Learning Needs

The provider will use school-based and school-focused services to support the specific learning and transitional needs of children in custody.

Commentary. Students in the care of the Department of Children's Services may at times need additional support services in order to function effectively in the public schools. DCS is committed to working in collaboration with local school systems to benefit the students in its care.

14. Changes in Educational Placement

The provider will monitor and limit changes in a student's educational placement in order to avoid disruptions in the learning process.

Commentary: When students must change schools several times, there is an obvious disruption in the educational process. Students are out of school for several days each time, and school records may not "catch up" with students, causing scheduling problems for the school and pupil. At times, credits are lost because students cannot continue the same classes at a new school. Students also must adjust to a new school environment with each move. The fewer times students must move, the more consistent and sequential the educational programming can be.

15. School Suspensions

When a child in DCS custody is suspended for more than ten (10) or more days in any school year, the regional DCS education specialist should be consulted for assistance.

16. Behavioral Problems

When notified by a resource parent that a child/youth is having behavioral problems at home and/or school significant enough to cause a future disruption of the child/youth's placement, the family services worker must contact the DCS Well-Being Unit immediately requesting assistance in obtaining in-home wraparound services for the child/youth and resource family. TennCare refers to these services as intensive mental health case management, CTT (Continuous Treatment Team), or CCFT (Comprehensive Child and Family Treatment), and they are available to children/youth in DCS custody who are in Level 2 placements or below.

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17. Records Transfers and School Changes

The provider will develop a process to ensure a quick transfer of records, information, and individual support when children change schools.

Commentary. A quick transfer of records from one school to another is vital to proper and prompt placement in the new school. Yet, this is one area that some states have reported as a major problem in educating students in custody. When records are delayed or not sent, students may be placed in inappropriate classes, may not receive credit for work completed, may be forced to repeat classes and state-mandated tests, and may not receive special education services. There must be a systematic method in place for the transfer of educational records. Family services workers must be trained to know what information needs to be exchanged between schools and how to request this information.

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Healthcare Consent Guidelines for Youth in DCS State Custody

*You are seeing a youth in the legal custody of the Tennessee Department of Children's Services. Unless the parents' rights have been terminated, DCS is merely the legal custodian – **not** the youth's legal parent or guardian. The parent(s) or guardian(s) have the legal authority to determine healthcare when their youth is in DCS custody. DCS policy is to involve the youth's parent or legal guardian in healthcare decision-making for the youth when possible and in the best interest of the youth. The DCS representative who is present at this appointment will be able to inform you of the guardianship status of the youth and persons responsible for making healthcare decisions.*

EMERGENCY HEALTHCARE (medical and behavioral) - The parent/legal guardian, DCS case manager, contract agency caseworker, or foster parent determine consent at the time care is needed. A licensed physician may perform emergency medical or surgical treatment on a youth without consent if the physician has a good faith belief that delay of care would result in serious threat to life or serious worsening of the youth's medical condition.

ROUTINE HEALTHCARE (medical and behavioral) - The parent/legal guardian, DCS staff or foster parent present determine consent (as representative of the legal custodian) for *ordinary and routine care*. *Extraordinary or non-routine* treatment will require the parent/legal guardian to determine care. If the parent/legal guardian is unavailable, DCS staff will consult their legal counsel for assistance in determining appropriate steps for consent. This may involve a hearing in juvenile court for the judge to order the extraordinary or non-routine medical care.

Note - If the youth is 14 years of age or older, Tennessee law presumes that they have the maturity to decide medical care, but this is determined on an individual case basis by the provider.

SURGERY - The parent/legal guardian determines consent. If the legal guardian cannot or will not be available or if termination of parental rights has occurred, then the DCS Regional Nurse has the responsibility of determining consent for *ordinary and routine surgery*. *Extraordinary surgical procedures* will require an order of the juvenile court (if the parent/legal guardian is unavailable or parental rights have been or are being terminated).

PSYCHOTROPIC MEDICATION - The parent/legal guardian determines consent if the youth is less than 16 years of age. The parent/legal guardian or legal custodian for a youth 15 years of age and under can consent to disclosure of the youth's confidential information. DCS has asked that the parent be present for this appointment or available by telephone to decide the care of the youth. If the parent cannot or will not be available to determine consent or if termination or parental rights has occurred or is in process, then the DCS Regional Nurse has the responsibility of determining consent. He or she is available by telephone (the number can be provided to you by the DCS representative present). The appropriate informed consent form may be faxed to him/her (again the number will be provided) for signature prior to initiation of medication usage. **The DCS Regional Nurse, as the representative of the legal custodian and acting in place of the parent**, may contact you with questions concerning diagnosis, nature and purpose of proposed treatment, risks and benefits of proposed treatment, alternative

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treatments, risks and benefits of alternative treatment, and risks and benefits of receiving no treatment.

Note - If the youth is 16 years of age or older, he or she has the same rights as adults with respect to outpatient and inpatient mental health treatment medication decisions, and confidential information (TCA 33-8-202). The youth has the right to determine parent involvement, including any use of medication. An outpatient facility or professional may provide treatment and rehabilitation without obtaining the consent of the parent, legal guardian, or legal custodian. We ask that appropriate DCS documents indicating the youth's consent to treatment be forwarded to the DCS Regional Nurse or Youth Development Center Nurse for tracking purposes.

EXCEPTIONS to parent/legal guardian/legal custodian determination of medical care

- Youth 16 years of age or older for mental health treatment
- "Mature" 14 year old youth, determined on individual case basis by provider
- Treatment of juvenile drug abuse, a physician may use his/her own discretion in notification of the youth's parents
- Prenatal care of a minor, a physician may use his/her discretion in notification of the youth's parents
- Contraceptive supplies and information
- Treatment of sexually transmitted diseases
- Emergency medical or surgical treatment

TREATMENT REFUSAL by parent/legal guardian or youth (14 years of age or older)

You, as the health care provider, in consultation with DCS will determine:

- if the treatment or procedure is medically necessary,
- if the youth may be harmed if he/she does not receive the treatment or procedure, and
- if DCS determines that the treatment is necessary to protect the youth from harm,

THEN DCS will contact the local DCS attorney regarding the need for judicial intervention.

*We hope these guidelines are informative and helpful in your care of this youth
and we thank you for the clinical services you are providing.*

SECTION 10

Provider Policy Manual GLOSSARY

A

Abscond – To depart without authority from the supervision of the Department of Children's Services in violation of the conditions of probation/aftercare.

ABUSE – Abuse exists when a person under the age of eighteen (18) is suffering from or has sustained or may be in immediate danger of suffering from or sustaining a wound, injury, disability, or physical or mental condition caused by brutality, neglect, or other actions or inactions of a parent, relative, guardian, or caretaker. Abuse can be physical, verbal, emotional, or sexual. (T.C.A. 37-5-103(1); DCS)

Acquired Immunodeficiency Syndrome (AIDS) – A result of human immunodeficiency virus (HIV) infection, making the immune system less able to fight infection. According to The Centers for Disease Control and Prevention guidelines, a CD4+ T-cell count below 200 mm in the presence of HIV infection constitutes an AIDS diagnosis. A positive HIV test result does not mean that a person has AIDS. A diagnosis of AIDS is made by a physician using certain clinical criteria (e.g., AIDS indicator illnesses). Infection with HIV can weaken the immune system to the point that it has difficulty fighting off certain infections. These types of infections are known as "opportunistic" infections because they take the opportunity a weakened immune system gives to cause illness. An HIV-infected person receives a diagnosis of AIDS after developing one of the CDC-defined AIDS indicator illnesses. An HIV-positive person who has not had any serious illnesses also can receive an AIDS diagnosis on the basis of certain blood tests (CD4+ counts). Many of the infections that cause problems or may be life-threatening for people with AIDS are usually controlled by a healthy immune system. The immune system of a person with AIDS is weakened to the point that medical intervention may be necessary to prevent or treat serious illness. Today there are medical treatments that can slow down the rate at which HIV weakens the immune system. There are other treatments that can prevent or cure some of the illnesses associated with AIDS. As with other diseases, early detection offers more options for treatment and preventative care.

Adjudication – The outcome of the court's process to determine the validity of allegations made in a petition or complaint. The process consists of the presentation of witnesses and evidence by oral testimony or written statements, and arguments by counsel or the parties. The court decides the case based on the proof presented by the parties and their arguments. For example, the court determines whether or not a child is dependent and neglected and then makes a disposition of the child either immediately or at a later date. (**See Disposition Hearing**)

Administer – The giving or application of a single dose of a drug to a patient by authorized health care personnel by ingestion, injection, inhalation, or other means.

Adoption – The social and legal process of establishing by court order, other than by paternity or legitimization proceedings or by voluntary acknowledgment of paternity, the legal relationship of parent and child.

Adoption Assistance – The federal or state programs available to adoptive parent(s) adopting special needs children to enable them to meet the child's maintenance, medical, psychological, or other needs.

Adoption Decree – See *Final Decree of Adoption*

Adoptive Family/Parent(s) – The people who have been made the legal parents of a child by the entry of an order of adoption.

Adoption Petition – The legal document that specifies the prospective adoptive family's intent and appropriateness to adopt a child and which seeks the establishment of legal relationship of parent/child.

Adoption Record – The confidential records, reports, or documents maintained in any medium by the department's staff, a licensed child-placing agency, or a licensed clinical social worker which contain any social, medical, legal, or other information concerning a child who is placed for the purpose of adoption.

ADOPTIONS SERVICES (as applicable to Continuums of Care) – Continuums are required to provide the full range of adoption services to all children in DCS full guardianship in the care of the continuum whose goal is adoption.

The continuum provider will provide full case management services (both those regular for foster care and those additional due to the child being in adoption status); perform all steps necessary to prepare the child for adoption; perform all steps necessary to provide diligent search for an adoption family and prepare the adoptive family; perform all services necessary to place the child for adoption including compliance with legal requirements and other binding documents, ICPC, and securing adoption assistance when the child is eligible; perform post-placement services through finalization of the adoption; provide post-finalization services; respond to disruptions; and complete all required reports and procedures including sealing of the adoption record. Continuum providers will be reimbursed at the per diem rate for the adoption services delivered up to the date of the signing of the adoption placement agreement with an adopting family.

Advocate – A knowledgeable individual familiar with departmental policies and grievance procedures.

Advocacy Contractor – A contracted advocacy agency that assists children in DCS custody in exercising their right to appeal TennCare services.

Aftercare – The period of supervision of a delinquent youth beginning at release from the custody of the Department of Children's Services and continuing until the youth is removed from legal supervision.

AIDS – See *Acquired Immunodeficiency Syndrome*

Arson – The act of willfully and maliciously setting fire to or burning, causing to be burned, or aiding, counseling, or procuring the unauthorized burning of any property, building, or any other structure, whether one's own property or that of another, and causing or having the potential to cause significant damage to person or property.

ART – Aggression Replacement Training. An intervention program designed to teach adolescents to understand and replace aggression and antisocial behavior with appropriate, positive alternatives.

Assault – An attempt (or the unequivocal appearance of an attempt) to do bodily injury with force or violence to another person, accompanied with the apparent present ability to do so.

Assessment – The ongoing evaluation process that is the foundation for all case management

decisions made for families and children relative to the intensity of their level of care services and type of placement, if out of home placement is warranted. An assessment is completed initially on every appropriate case type and then is updated accordingly at all relevant decision making points initially and throughout the life of the case.

Attorney ad Litem – An attorney appointed by a court to represent the wishes and interests of an individual during court proceedings for determining the need for a conservator.

Aversive stimuli – Painful or noxious stimuli, which are employed to reduce the frequency of or to eliminate problem behavior.

B

BEHAVIOR MANAGEMENT – Behavior management is the use of specialized interventions to guide, redirect, modify, or manage behavior of children and youth. Behavior management includes a wide range of actions and interventions used in a broad variety of settings in which adults are responsible for the care and safety of children and youth. These settings include, but are not limited to, residential group care, family foster care, psychiatric hospitals, day treatment, child day care and school age child care, in-home services, educational programs, shelter care, and juvenile detention. Behavior management includes the entire spectrum of activities from preventative and planned use of the environment, routines, and structure of the particular setting to less restrictive interventions such as positive reinforcement, verbal interventions, de-escalation techniques, therapeutic activities, and loss of privileges; to more restrictive interventions such as time-out, physical escorts, physical/chemical/mechanical restraints, and seclusion. (CWLA)

BHO – Behavioral health organization

Birth Family – Members of a child's birth mother's and/or birth father's families.

Birth Parent(s) – The biological parents of a child.

C

Cardiopulmonary Resuscitation (CPR) – A life-saving procedure that includes the timed external compression of the anterior chest wall to stimulate blood flow by pumping the heart and alternating with mouth-to-mouth breathing to provide oxygen.

Caretaker – Person responsible for a child's care, whether a parent, legal guardian, or an adult temporarily in a parent's role, as in institutional or out-of-home settings.

Case Aide – An individual who was solely hired to assist family services workers in their routine job performances.

Case File/Record – A collection of data pertaining to an individual client including the complete set of information related to a client such as demographic, assessment, treatment, health, service, placement, and individual outcome data. The status of a case record can be described by one of three options:

Pending – A decision regarding the formal opening of a case has not been made, although some work is being performed on behalf of the child or family by DCS staff.

Open – A case has been assigned to a DCS staff member with the expectation that work will continue to be performed and services provided to the client. A case file is created for recording progress and events related to the care of the child.

Closed – The termination of the physical custody, control and/or supervision of a youth the Tennessee Department of Children's Services.

CASE MANAGEMENT (as applicable to continuums of care) – Case management/coordination services are provided by a family services worker who, at a minimum, has a bachelor's degree in one of the social sciences and at least one year of social services experience. Case management includes coordination with the child and family team in the development and implementation of the treatment plan and family service plan, monitoring the implementation of the plan, and locating all services and placements a child and/or family may need while enrolled in the continuum. Case management includes participating in all child and family team meetings as well attending all foster care review meetings and court hearings. It also includes documenting progress, barriers, and resolution to those barriers; maintaining contacts with the custody department personnel; revising the treatment plan as needed; maintaining ongoing contacts with the child and/or family; and planning and implementing the progression of the child and/or family through the continuum. Child and family meetings will be used at all critical decision-making points as outlined in the Engaging Families Policy.

Case Notes – Chronological notes entered into a case file. (*See Case Recordings*)

Case Recordings – The ongoing chronological narrative written by a family services worker in a case file that serves to document each contact or to document any activity related to the case.

CCFT – Comprehensive child and family treatment

CFCIP – See Chaffee Foster Care Independent Living

CFSR – Child and Family Services review

CFTM – Child and Family Team Meeting

Chaffee Foster Care Independent Living (CFCIP) – A grant to assist states and localities in establishing and carrying out programs designed to assist foster youth likely to remain in foster care until 18 years of age and youth who have left foster care because they attained 18 years of age (but have not yet attained 21 years of age) to make the transition from foster care to independent living.

Child – A person who, by reason of minority, is legally subject to parental guardianship or similar control.

CHILD AND FAMILY TEAM MEETING (CFTM) – The Child and Family Team Meeting (CFTM) is used by DCS staff to engage families in the decision-making process throughout their relationship with the department. They are used for the development of case plans and making permanency decisions as well as for addressing critical decisions around the placement of children. When the permanency plan is completed, the plan serves as the documentation of the child and family team's work. For all others, the team's work and decision(s) are documented in the staffing summary and justification form. Also used CFT, child and family team.

CHILD PLACEMENT SPECIALIST – A DCS family services worker who places children with provider agencies, facilities, or in resource homes for temporary care.

Child-Placing Agency – Any institution, society, agency, corporation, or facility that places

children in foster homes for temporary care or for adoption. A license issued to a child-placing agency includes all boarding homes and family day care homes approved, supervised, and used by the licensed agency as a part of its work.

Child Protective Services (CPS) – A program division of DCS whose purpose is to investigate allegations of child abuse and neglect and provide and arrange preventive, supportive, and supplementary services.

Child Sexual Abuse – Any act involving the unlawful sexual abuse, molestation, fondling, or carnal knowledge of a child as stated in TCA 37-1-602. The employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or simulation of such conduct for the purpose of producing a visual depiction of such conduct, or the rape, and in cases or caretaker or inter-familial relationships, statutory rape, molestation, prostitution, or other form of sexual exploitation of children, or incest with children.

Child Welfare Benefits Counselor (CWBC) – The DCS staff assigned to process the Benefits Application and establish a foster child's eligibility for federal benefits. CWBCs are responsible for certifying a foster child's eligibility for Title IV-E foster care, Medicaid and coordinating the federal application process for SSI, Title II Social Security, and Veteran's benefits.

CHEMICAL RESTRAINT – Chemical restraint involves the use of a psychoactive drug or medication to temporarily and involuntarily immobilize an individual or otherwise limit a person's freedom of movement. Psychotropic medication shall not be used as a means of control or discipline of children or for the convenience of the treating facility. Chemical restraints are different from the ongoing use of medication for the treatment of symptoms of underlying psychiatric illness.

Classification – An on-going and comprehensive process of evaluation of a youth committed to the Department of Children's Services to identify problems and strengths, formulate treatment recommendations, and determine placement based upon individual needs and available resources.

Community Residential Facilities – Community-based residential treatment facilities (group homes) staffed and operated by the Department of Children's Services.

COMMUNITY SUPPORT SERVICES – Identification, recruitment, development, and referral to community services to support the service needs of the child and/or family to maintain and facilitate permanency. Coordination with community support is an essential component of services to children and families.

Confinement – Placement of a youth in a secure environment separate from the regular population.

CONSEQUENCES – A logical or natural conclusion (cause and effect) following a behavior that serves to increase or decrease the likelihood that a particular behavior will reoccur.

Conservator – Someone appointed by a court to whom an individual's rights have been transferred. For example, the right to make decisions about treatment or medical care may be transferred from the individual to the conservator, giving the conservator the authority to consent or refuse medical treatment on behalf of the individual.

Continuum of Care – A service-based system of care which allows flexibility in designing services for the child/family, the ability to facilitate rapid movement of the child through the

service system, and the ability to “customize” the delivery of services to each child and family in the least restrictive, and most cost-efficient manner.

Continuum-of-Care Contract – A formal written agreement to provide service-based care. (See *Continuum of Care*)

CONTRABAND – Any item possessed by an individual or found within the facility that is illegal by law or that is expressly prohibited by those legally charged with the responsibility for the administration and operation of the facility or program and is rationally related to legitimate security, safety, or treatment concerns. (State of Tennessee DCS modified)

Contraindication – A symptom or condition that makes a particular treatment or procedure inadvisable.

Controlled Substance – Refers to any substance included in schedule I, II, III, IV, or V of 21 USC 812 or any other federal regulations. Such substances include, but are not limited to, marijuana, cocaine, “crack” cocaine, PCP, LSD, heroin, etc. Prescription drugs not prescribed by a licensed physician are also included.

COORDINATION OF MEDICAL AND NURSING SERVICES – Coordination and documentation of all Early Periodic Screening Diagnosis and Treatment (EPSDT) services provided by a licensed physician or licensed registered nurse of the type and duration indicated by documented medical need.

COORDINATION OF THERAPY SERVICES – Referral and coordination of medically necessary outpatient therapy services as indicated in the child’s permanency plan and/or prescribed to meet the mental health needs of the child.

CORPORAL PUNISHMENT – The intentional application of painful stimuli to the body in an attempt to terminate behavior, or as a penalty for behavior. This does not include aversive stimuli. (State of Tennessee MHDD)

COUNSELING – Nonmedically necessary intervention and support services—in the form of individual, group, or family counseling—that address behavioral or mental health needs impairing social, educational, or psychological functioning.

court Order – An order, decree or directive from a judge, referee, or court of competent jurisdiction over the matter at issue.

Court Report – The written report to the court in response to an Order of Reference in an adoption proceeding which describes to the court the status of the child and the prospective adoptive parent(s) or the persons to whom the child is surrendered. Such a report may be preliminary, supplementary, or final in nature.

CPR – See *Cardiopulmonary Resuscitation*

CPS – See *Child Protective Services*

CRISIS INTERVENTION/STABILIZATION – Services provided on a 24-hour basis to a child and/or family experiencing a medical, mental health, parent/child interaction, or other significant emergency need. At a minimum, services must be provided by an individual with a bachelor’s degree in one of the social sciences with one year experience and with supervisory access to a licensed professional possessing, at a minimum, a master’s degree in one of the behavioral sciences.

CTT – Continuous treatment team

Custody – The control of actual physical care of the child and includes the right and responsibility to provided for the physical, mental and morale well-being of the child [TCA 37-1-102 (b) (8)].

CWBC – See *Child Welfare Benefits Counselor*

D

Delinquent act – An act designated a crime under the law, and that would be considered a crime if committed by an adult. This includes local ordinances and federal law, excluding traffic offenses other than failure to stop when involved in an accident, driving under the influence, vehicular homicide, or any other traffic offense classified as a felony. [TCA 37-1-102.]

Delinquent child – A child who has committed a delinquent act and is in need of treatment and rehabilitation. [TCA 37-1-102.]

Dependent and Neglected Child – A child who is without a parent, guardian, or legal custodian; whose parent, guardian, or person with whom the child lives, by reason of cruelty, mental incapacity, immorality, or depravity is unfit to properly care for the child; who is under unlawful or improper care, supervision, custody, or restraint by any person, corporation, agency, association, institution, society, or other organization or who is unlawfully kept out of school; whose parent, guardian, or custodian neglects or refuses to provide necessary medical, surgical, institutional, or hospital care for the child who, because of lack of proper supervision, is found in an unlawful place; who is in such condition of want or suffering or is under such improper guardianship or control as to injure or endanger the morals or health of himself/herself or others; who is suffering from or has sustained a wound, injury, disability, or physical or mental condition caused by brutality, abuse, or neglect; who has been in the care and control of an agency or person who is not related to the child by blood or marriage for a continuous period of 18 months or longer in the absence of a court order, and the person or agency has not initiated judicial proceedings seeking either legal custody or adoption of the child; who is or has been allowed, encouraged, or permitted to engage in prostitution or obscene/pornographic photographing, filming, posing, or similar activity and whose parent, guardian, or other custodian neglects or refuses to protect the child from such activity [TCA 37-1-102(b)(12)]

DESIGNEE – An individual who has been appointed or assigned to serve in a particular legal or official capacity.

Detention – The confinement of a child in a secure area.

Detoxification – Treatment designed to free an addict from his/her alcohol or drug habit.

Developmental Disability – A condition based on having either a severe or chronic disability or mental retardation. [TCA 33-1-101(10)]

DIETETIC AND NUTRITION SERVICES – Services that are necessary to address issues related to diabetes control, obesity, malnutrition, and/or eating disorders.

DILIGENT SEARCH – This service is a search for potential family members to be a support or placement for a child and/or recruitment of a family or an individual to be an adoptive, foster, relative, or planned permanency living arrangement support for a child.

Discharge – The termination of physical custody, control, and/or supervision of a delinquent

youth by the Tennessee Department of Children's Services.

Discipline – Any action taken by a facility for the purpose of punishing or penalizing residents.

DISPENSE – In a DCS facility, to issue to a patient or to a person acting in his/her behalf one or more unit doses of a drug in a suitable container with appropriate labeling. Dispensing includes the act of packaging a drug, either from a bulk container or as a result of compounding, in a combination other than the original container of the manufacturer or distributor and labeling the new container with all the information required by the state and federal law. Except for physicians or dentists, the act of dispensing is limited to licensed pharmacists and persons working under their immediate supervision and may not be performed by a nurse or other non-pharmacist. (State of Tennessee DCS)

'Dispense' means to deliver a controlled substance to an ultimate user or research subject by or pursuant to the lawful order of a practitioner, including the prescribing, administering, packaging, labeling, or compounding necessary to prepare the substance for that delivery.
(T.C.A. 39-17-402(7) Criminal Offenses; Drugs)

Drug – A substance other than food intended to affect the structure or function of the body; any controlled substance subject to testing pursuant to drug testing regulations adopted by the U.S. Department of Transportation. A covered employer shall test an individual for all such drugs in accordance with the provisions of T.C.A. § 50-9-101, et. Seq. The Commissioner of Labor and Workforce Development may add additional drugs by rule in accordance with T.C.A § 50-9-111.

Drug Addiction – The compulsive need for and use of a habit-forming substance characterized by tolerance and by well-defined physiological symptoms upon withdrawal of the substance.

DSM – See *Diagnostic and Statistical Manual of Mental Disorders*

Due Process – Judicial or administrative proceedings designed to safeguard the legal rights of an individual consisting of giving notice of charges, allegations, changes in status, and providing appropriate persons the opportunity to be heard or to present evidence on the individual's behalf.

E

Early Periodic, Screening, Diagnostic and Treatment Services (EPSDT) – Preventive health care services provided under TennCare to children under the age of 21, insuring that children have a comprehensive health program. This is a required service under Federal Medicaid law and thus, is required in Tennessee's Managed Care Medicaid program (TennCare).

Eligibility – The process of determining the benefits for which a child may qualify.

Emergency Evaluation for Inpatient Psychiatric Hospitalization – The Specialized Crisis Services (SCS) as operated by Youth Villages, Inc., should be contacted any time a child is being considered for inpatient hospitalization. For a crisis that presents immediate danger for harm, the team is required to respond within one (1) hour. For a crisis that does not present immediate danger, the team is required to respond within four (4) hours.

In the event a child seventeen (17) years of age and under is determined to meet criteria for inpatient hospitalization by Youth Villages Specialized Crisis Services, the SCS will first contact AdvoCare to present the case for precertification. However, in the event of the need for an involuntary emergency hospitalization commitment (e.g., the child is over age 16 and is

refusing admission, or under age 16 and the guardian is refusing admission), precertification by AdvoCare is not required. Instead, SCS will call AdvoCare to notify admission of the child. If SCS cannot provide a timely response, a medical doctor or other mental health professional can arrange an involuntary commitment and SCS will assist with notification of the admission to AdvoCare.

EMERGENCY PLACEMENT SERVICES – Services available 24 hours per day through an on-call system that stabilize children and families by locating alternative short-term placements in emergency situations.

EMOTIONAL ABUSE – Emotional abuse includes verbal assaults, ignoring or being indifferent to a child, or constant family conflict. If a child is degraded enough, the child will begin to live up to the image communicated by the abusing parent or caretaker. (State of Tennessee DCS)

EPSDT – *See Early Periodic Screening Diagnosis and Treatment*

ESCAPE – A child or youth who has unlawfully departed from a secure location or situation, i.e., youth development center, physical restraints, or secured transportation, is said to have escaped (State of Tennessee DCS). ‘Escape’ means unauthorized departure from custody or failure to return to custody following temporary leave for a specific purpose of limited period, but does not include a violation of conditions of probation or parole.(39-11-602 Criminal Offenses; Justification Excluding Criminal Responsibility)

EXCEPTION – Exceptions are deviations from Brian A. directives.

F

Facility Case Manager – The case manager at a residential program, i.e., youth development center, community residential facility (group home), or contract agency.

FAMILY Functional Assessment – The Family Functional Assessment is a shared information gathering and assessment process for the family and their team. Within the context of the assessment interviews and the team meetings, case workers will be able to assist the family in identifying their own strengths and needs. The case worker and the family begin the process as they listen and understand the family story . All team members contribute with informal and formal information that they share with the family and their team. As the team progresses in the assessment process, they seek missing information, create a long -term view for the family, receive information from external evaluations and records, prioritize needs, analyze and interpret information, look for underlying needs, find strengths and resources to be used in planning, and draw conclusions from available information.

FAMILY PLANNING COUNSELING AND REFERRAL – Education and guidance provided to a child and/or family regarding planning/preventing childbirth. These services may include alternatives available for pregnant teens.

FAMILY SERVICES – Services provided to family members and persons identified in the permanency plan or child and family team meeting or who are identified as discharge options which facilitate reunification, permanency, or adoption. Services to families include linking families to community resources and services to increase stability and meet the goals of the permanency plan. Services to the family begin at the admission of the child into the contract and are fully incorporated into all treatment plans. Flexible funding may be requested through the home county family services worker to address the basic living needs of the family (rent,

utilities, child care, etc.) or identified service needs that are not covered in the scope of services.

Family Services Worker (FSW) – A DCS employee responsible for providing case management services to children under the state’s supervision, in state custody, or at risk of state custody and their families.

Felony – Any offense punishable by death or imprisonment for a term of one year or more. Tennessee law has various classes of felonies (A, B, C, etc.) with varying sentences for each class.

FFA – *See Family Functional Assessment*

Fighting – A physical altercation between two or more persons without weapons.

Flex Funds – Monetary resources made available for the purpose of acquiring additional services or goods that can be used to prevent the need for state custody or to return a child home who is in state custody.

Force/Coercion – The actual use or threat of physical violence or any other unlawful act causing any person to act, move, or comply against his/her resistance.

FOSTER CARE – Each continuum has a separate foster care contract. When a child and family team determines that the child and family do not require wraparound services, intensive behavioral intervention, and intensive case management, the team may recommend movement or transition from the continuum contract to a foster care contract.

Foster Care Review Board – An advisory body appointed by a juvenile court judge(s) to review the case status of each neglected, dependent, and unruly child in DCS custody at least once within the first 90 days of initial placement in DCS custody and within every 6 months thereafter.

Foster Home – *See Resource Home*

Foster Parent – *See Resource Parent*

FSW – *See Family Services Worker*

Full Guardianship – The legal status of a child when all parental rights to the child have been terminated by surrender, court order, or clearing the Putative Father Registry and DCS has guardianship of the child with the right to consent to the child’s adoption.

G

GAL – *See Guardian ad litem*

Goods – Tangible items.

Grievance – A complaint concerning an alleged unjust circumstance or action toward a youth in custody.

Guardian – An individual who, if appointed by the court or if acting under statute, has all the duties of a parent to provide for the child’s support, education, and medical care, subject only to the parent’s, if any, remaining rights. Parents are natural guardians of a child. The court may appoint a guardian for a child whose parent(s) is (are) deceased. The court may give guardianship to DCS following a termination of parental rights. DCS may act as guardian when there is no natural guardian or when a minor has been abandoned.

Guardian Ad Litem (GAL) – The attorney appointed to represent the best interests of the child in court proceedings. The Guardian Ad Litem's role differs from that of an attorney for the child, in that the child's attorney is bound to do what the child, his client, directs, while the Guardian Ad Litem must represent the child's best interests to the court, even if the child's best interests differ from what the child wants. The Guardian Ad Litem represents the child in litigation only but is not responsible for the child's care on a daily basis.

H

Hazardous Material – A material or substance that exposes one to risk or harm by its chemical composition.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) – A federal law to promote the *portability* of insurance coverage, which waives preexisting conditions when an employee changes jobs, and *accountability* by providing funding for, and strengthening of enforcement and compliance with, healthcare regulations.

Hearing (s) – A proceeding to determine a course of action, such as the placement of a juvenile offender, or to determine innocence in a disciplinary matter. Arguments, witnesses, or evidence are heard by a judicial officer or administrative body in making the determination.

Hearing Officer – A full-time staff member appointed by the facility administrator and authorized to conduct hearings and impose disciplinary actions that comply with the policies and procedures of the facility. The hearing officer shall not be the reporting staff member or a witness to the incident to be heard.

HIPAA – *See Health Insurance Portability and Accountability Act of 1996*

HIV – *See Human Immunodeficiency Virus*

Home Pass – For adjudicated delinquent youth, a court and DCS authorized visit that does not exceed 48 hours to the student's home in the physical custody of the student's family (parent/legal guardian/approved relative).

Home Study – The process of assessing and evaluating relatives or friends of the family to determine their suitability and willingness to provide a placement for the child before or after she/he comes into foster care.

Human Immunodeficiency Virus (HIV) – The virus that causes AIDS weakens several body systems and destroys the body's immune system, making it easier for life-threatening cancers or opportunistic infections to invade the body. The virus is passed from one person to another through body fluids including blood, semen, vaginal fluid, breast milk, and through sexual contact. Infected pregnant women can pass HIV to their babies during pregnancy or delivery, as well as through breast-feeding. Most HIV-infected people will develop AIDS. Healthcare workers may come in contact with additional body fluids that may transmit the virus such as cerebrospinal fluid (surrounding the brain and the spinal cord), synovial fluid (surrounding bone joints), and amniotic fluid (surrounding a fetus *in utero*).

I

ICPC – **See** *Interstate Compact on the Placement of Children*

IDEA – **See** *Individuals with Disabilities Education Act*

IEAP – Abbreviation referring to the Inter-Ethnic Adoption Provision that amended the Multi-Ethnic Placement Act (MEPA) in 1996. IEAP is commonly referred to as, and used interchangeably with, IEPA. This term refers to placements of children who fall within coverage provided under Section 1808 of P.L. 104-188 [42 USC 1996b]—the Removal of Barriers to Interethnic Adoption Act—which affirms the prohibition against delaying or denying the placement of a child for adoption or foster care on the basis of race, color, or national origin of the foster or adoptive parents or of the child involved.

IEP – **See** *Individualized Educational Program*

IEPA – Abbreviation that refers to the Inter-Ethnic Placement Act - IEAP is commonly referred to as, and used interchangeably with IEPA. (**See** *Inter-Ethnic Adoption Provision*)

Imminent Danger of Harm – The substantial possibility that bodily harm or great bodily harm will come to the child in the reasonably foreseeable or immediate future, whether or not the child has already suffered bodily harm or great bodily harm, given the child's risk environment (i.e., the unique combination of child vulnerabilities, the parent's or caretaker's ability to protect and care for the child, the family's support system, and related factors); also called threat of harm. Examples include the use of a life-threatening weapon (even if no actual injury occurs); a severely mentally ill or psychotic parent; a parent whose substance abuse habits or other disabilities chronically place the child in hazardous situations; a parent who fears the child or fears hurting the child; a parent who has killed or seriously injured another child and has not successfully completed treatment; or any actual minor injuries that could reasonably be expected to have more serious consequences for the child if they were to occur again. (State of Tennessee DCS) 'Imminent danger' means conditions calculated to and capable of producing within a relatively short period of time a reasonably strong probability of resultant irreparable physical or mental harm and/or the cessation of life if such conditions are not removed or alleviated." (T.C.A. 71-6-102(9) Welfare; Adult Protection)

INDEPENDENT LIVING SERVICES – These services include counseling, skill building, service coordination, and life skills coaching/support that focus on facilitating the skills and support for the child to live successfully and independently in the community. Age-appropriate self-sufficiency skills must be incorporated into treatment plans for all children. Children ages fourteen (14) and above must have specific independent living skills training and development incorporated into service and treatment plans. Establishing connections with persons able to provide support throughout the child's life is an essential component of this service and to successful independence. (Chaffee Independent Living Funding may be used to augment services as outlined in the Independent Living Policy.)

Individual Program Plan (IPP) – is the method used by DCS to document the needs of its youth and the provision of meeting those needs with treatment modalities. The IPP process is the basis for determining progress toward desired goals and eventual discharge.

Individualized Educational Program (IEP) – A written record of the decisions reached by members of an M-Team stating specific educational and related services designed to meet the individual needs, interests, and abilities of each youth determined to be disabled.

Individuals With Disabilities Education Act (IDEA) – A coordinated set of activities for a student, designed within an outcome-oriented process, which promotes movement from school

to post-school activities, including post-secondary education, vocational training, integrated employment (including supported employment), continuing and adult education, adult services, independent living, or community participation. The coordinated set of activities shall take into account the student's preferences and interests, and shall include instruction, community experiences, the development of employment and other post-school adult living objectives, and, when appropriate, acquisition of daily living skills and functional vocational evaluation [*Education of the Handicapped Act Amendments of 1990, PL 101-476, section 602 (a)*].

INFORMED CONSENT – Informed consent is the right of every patient to have information regarding prescribed tests or treatments including all risks related to the tests or treatments and all benefits of the tests or treatments. The patient has a right to sufficient information to allow the patient to make an informed decision about whether to consent to the treatment or tests. (DCS- Policy 20.24)

Defined in the negative as follows: (T.C.A. 29-26-118 Providing Inadequacy of Consent)
“In a malpractice action, the plaintiff shall prove . . . that the defendant did not supply appropriate information to the patient in obtaining informed consent (to the procedure out of which plaintiff's claim allegedly arose) in accordance with the recognized standard of acceptable professional practice in the profession and in the specialty, if any, that the defendant practices in the community in which the defendant practices and in similar communities.”

IN-HOME SERVICES – A wide array of services offered to families and children placed with family members. These services are coordinated and include, but are not limited to, services identified in the permanency plan as necessary to achieve permanency and stability for the child and family. Services must meet standards outlined in the Provider Policy Manual.

In-Service Training – Courses that provide the opportunity for further development and specialization and are offered by DCS and/or its contractors, Training Division of the Department of Personnel, and Office of Information Resources (OIR).

INTENSIVE DAY TREATMENT – Involves structured group activities in residential and group care designed to encourage, direct, and instruct children in the acquisition of skills needed to develop self-sufficiency and personal competence as well as prevent or reduce the need for institutionalized care. Programs must operate or subcontract for intensive day treatment services licensed through the Tennessee Department of Mental Health/Developmental Disabilities for access by children identified as needing this level of intervention.

Interpreter – A person who translates orally for parties conversing in different languages.

Interstate Compact on the Placement of Children (ICPC) – A uniform law enacted by all fifty states, the District of Columbia, and the Virgin Islands that establishes orderly procedures for the placement of children across state lines into other party states for the purpose of foster care or preliminary to an adoption and fixes responsibility for those involved in placing the child.

INVOLVED ADULT – a biological relative or a present or former foster parent who is identified as being currently involved in a child's life to the extent that it is appropriate for that adult to contribute to decision making regarding the child's care. It is the responsibility of the DCS family services worker to identify such individuals and insure their inclusion in the child's permanency plan.

IPP – See *Individual Program Plan*.

ISOLATION – **See Seclusion.** Isolation is defined as a form of seclusion. DCS does not use or recognize the term “isolation.” Please refer to the definition of seclusion.

J

JCAHO – **See** *Joint Commission on Accreditation of Health Care Organizations*

Joint Commission on Accreditation of Health Care Organizations (JCAHO) – The Joint Commission evaluates and accredits more than 16,000 health care organizations and programs in the United States. An independent, not-for-profit organization, JCAHO is the nation’s predominant standards-setting and accrediting body in health care. Since 1951, JCAHO has developed state-of-the-art, professionally based standards and evaluated the compliance of health care organizations against these benchmarks.

Juvenile – A person under the age of 21, or as defined in the local jurisdiction as under the age of majority.

Juvenile court – A court with jurisdiction under Tennessee statutes to hear and decide matters pertaining to children.

L

Label – Any written, printed, or graphic material displayed on or affixed to containers, usually of hazardous materials.

Level II Alcohol And Drug Treatment Program – Provides treatment to youth who have been identified by an assessment as alcohol and drug users.

Level III Alcohol And Drug Treatment Program – Inpatient/residential treatment at a facility other than a youth development center for youth who are chemically dependent and can no longer function in their environment.

Licensed Child Placing Agency – Any agency operating under a license to place children for adoption in this state. [TCA 36-1-102(28)]

Licensed Clinical Social Worker – An individual who holds a license as an independent practitioner from the board of social worker certification and licensure and, in addition, is licensed by the department to provide foster care placement services and adoption placement services.

Licensed Independent Practitioner – An individual licensed by the State of Tennessee Health Related Boards as one of the following and privileged by the hospital medical staff and governing body to authorize the use of restraint.

- Medical doctor
- Doctor of Osteopathy
- Physician Assistant
- Certified Nurse Practitioner
- Nurse with a master’s degree in nursing, who functions as a psychiatric nurse and is certified to prescribe medication

- Psychologist with health service provider designation
- Licensed clinical social worker
- Licensed professional counselor
- Senior psychological examiner
- Other licensed mental health professional permitted by law to practice independently.

M

M-TEAM – See Multidisciplinary Team

MACE – Any chemical agent used for control purposes. (DOE)

Maltreatment – Any recent act or failure to act on the part of a parent or caretaker that results in death, serious physical or emotional harm, or sexual abuse or exploitation or which presents an imminent risk of serious harm. (State of Tennessee DCS)

Managed Care Organization (MCO) – A system of health care delivery that influences utilization and cost of services and measures performance.

McKinney-Vento Homeless Education Act of 2001 – Federal Law that mandates each State educational agency shall ensure that each child of a homeless individual and each homeless youth has equal access to the same free, appropriate public education, including a public preschool education, as provided to other children and youths. (*Individuals with Disabilities Education Act, 20 U.S.C. Sec. 1400 et. seq.; McKinney-Vento Homeless Education Act of 2001.*)

MCO – See *Managed Care Organization*

Medical necessity – Medical services that are

- Calculated to prevent, diagnose, correct, or ameliorate a physical or mental condition that threatens life, causes pain or suffering, or results in illness, disability, or infirmity **or** calculated to maintain or preclude deterioration of health or functional ability;
- Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness, disability or injury under treatment, and not in excess of the individual's needs;
- Necessary and consistent with generally accepted professional medical standards as determined by the Secretary of Health and Human Services or the state Department of Health; and
- Reflective of the level of service that can be safely provided, and for which no equally effective treatment is available.

Mechanical Restraint – A mechanical device that is designed to restrict the movement of an individual, such as handcuffs or wristlets, chains, anklets, or ankle cuffs or any other DCS-approved or authorized device used to limit the movement of the juvenile's body. (DOE) (See DCS PPM Sect. V. – Use of Mechanical Restraint)

Medical Treatment – Treatment, other than first aid, administered by a physician or by licensed personnel under the standing orders of a physician.

MEDICAL CONFINEMENT – Separation of an individual youth from the general population in order to protect the health of that youth, the general population, and the institutional staff. Such confinement shall only be determined and ordered by a licensed physician or other qualified

and authorized person acting under medical protocol. (DOE)

MEDICATION ERROR – A medication error is when a prescribed medication (substance) is not administered according to physician's orders (e.g., missed dose, dose administered at wrong time or day, medication given to wrong individual).

Mental Health Professional (Qualified) – A person who is licensed in the state, if required for the profession, and who is a psychiatrist; physician with expertise in psychiatry as determined by training, education, or experience; psychologist with health service provider designation; psychological examiner; social worker who is certified with two (2) years of mental health experience or licensed; marital and family therapist; masters degreed nurse who functions as a psychiatric nurse; professional counselor; or if the person is providing service to service recipients who are children, any of the above educational credentials plus two (2) years of full-time mental health experience with children. *TCA 33-1-101*

Mental Illness (mental disorder) – As determined by a mental health professional, a clinically significant behavioral or psychological syndrome or pattern that occurs within an individual and that is associated with distress or impairment in one or more areas of functioning (e.g., social or academic functioning) or is associated with increased risk of death, pain, disability, or loss of freedom.

Mental Retardation – An IQ score of 75 or below in a standardized individually administered measure of intelligence accompanied by significantly impaired adaptive behavior (e.g., scores below the tenth percentile on a standardized measure of adaptive behavior) and that has an onset prior to the age of 18 years.

MEPA – See *Multi-Ethnic Placement Act*

Minor – Any person under eighteen (18) years of age.

Multidisciplinary Team (M-TEAM) – A team whose purpose is to (1) determine eligibility of a youth for Special Education and related services and (2) develop an individualized education program (IEP) for eligible students. This team may be the same as the program or classification staffing team but must include (1) a representative of the school system, other than the child's teacher, who is qualified to provide or supervise the provision of appropriate special education services; (2) a teacher qualified to teach a student in the student's area of suspected disability; (3) one or both of the student's parents; (4) the student, if appropriate; (5) a person knowledgeable of evaluation procedures, evaluation results, and the child; (6) if a learning disability is suspected on diagnostic examinations; and (7) other persons at the discretion of the parents or as needed to determine eligibility. A single member of the M-Team may meet two or more qualifications but the team must have at least three members.

Multi-Ethnic Placement Act – Legislation allowing the placement of children with families across ethnic and racial lines.

N

Neglect – Acts of commission or failure to provide for basic needs of a child including but not limited to food, medical care, and safe living conditions.

O

OTC – Over-the-counter (as in nonprescription medications).

OUT OF CONTROL – A student's behaviors shall be characterized as “out of control” at times when the youth actively demonstrates disruptive or assaultive behavior, or the intent to do such, to the extent that there is a serious or immediate threat to him or her, other students or staff members, and/or property. (DOE)

P

PARENTING SKILLS TRAINING – Individualized coaching and training to assist parents with issues related to discipline, child development, child-rearing skills, and behavioral intervention. Services must meet the needs of the family as identified in the permanency plan and be available at times and locations that best meet the family's needs.

Parents – Refers to biological parents or legal guardians.

Parents As Tender Healers (PATH) – Training for foster care, kinship care, and adoptive parents consisting of approximately 27 hours of classroom time and homework assignments.

Parental Rights – Legally recognized rights and responsibilities to act as a parent, to care for, to name, and to claim custodial rights with respect to a child.

Partial Guardianship – The legal status of a child when the rights of at least one, but not all, parents or guardians have been terminated or are undetermined.

Pass – Any authorized absence by a delinquent youth from his/her placement without staff supervision.

PATH – *See Parents As Tender Healers.*

Permanency Planning – The process of choosing and working toward the most appropriate setting or environment to achieve a permanent outcome for the child, i.e., return to parent, relative placement, adoption, independent living, or permanent foster care, in a timely manner.

Permanency SPECIALIST – The DCS worker responsible for facilitating the adoption process for eligible families and children.

Petition – A formal written application to the court requesting judicial action on a certain matter.

PHYSICAL ABUSE – Physical abuse is defined as nonaccidental physical trauma or injury inflicted by a parent or caretaker on a child. It also includes a parent's or a caretaker's failure to protect a child from another person who perpetrated physical abuse on a child. In its most severe form, physical abuse is likely to cause great bodily harm or death.

PHYSICAL ESCORT – The temporary holding of an individual for the purpose of guiding him/her to a designated location.

Physical Exam – A medical examination performed by a licensed health care professional for the purpose of diagnosing disease or illness or to determine the existence of injuries and whether those injuries were caused by abuse.

Physical Intervention – Physical handling beyond verbal command.

Physician Preceptor – A licensed physician who is responsible for supervising the clinical practice of a medical associate such as a nurse practitioner or physician's assistant.

PHYSICAL RESTRAINT – The involuntary immobilization of an individual without the use of mechanical devices. (See DCS PPM Sect. IV. – Use of Physical Restraint)

Placement – The arrangement for the care of a child in a boarding home or child-caring agency or institution.

Placement Services Division (PSD) – Formerly known as Resource Management.

Placement Services Worker (PSW) – Formerly known as the Resource Manager.

PLACEMENT STABILITY AND INTERVENTION – Wraparound, emergency response, crisis intervention, or child/family specific intervention and support that stabilize placement and avoid movement or disruption. Services are available on a 24-hour on-call basis.

Policy – (1) A course of action adopted by and pursued by an agency that guides and determines present and future decisions and actions. Policies indicate the general course or direction of an organization within which the activities of the personnel must operate. (2) A type of position statement; a philosophy, a mission, or a general objective. Anything that establishes a guideline for users is a policy.

POST-CUSTODY – After leaving custody

Pre-Placement Conference – A meeting held between the child's social counselor and the prospective adoptive family's social counselor to supplement information obtained through preplacement summaries and adoptive home studies. The purpose of the conference is to discuss adoption issues in order to determine the appropriateness of the placement.

Pre-Placement Summary – A document that provides a current description of a child considered for adoption, the birth family, and the type of adoptive parents needed for the child.

Presentation Summary – A non-identifying summary about a child for the family services worker's oral presentation of that child to the prospective adoptive family.

Pre-Service Training – Courses that provide the required basic knowledge and skills to perform important job tasks and prepare for independent work.

PRN – Abbreviation for the Latin *pro re nata*, which means "use as needed or according to circumstances." Five variables to be considered in the treatment plan:

1. Entry criterion. Define the specific index behavior indicating PRN use, including the frequency and intensity (or the specific situation for PRN use).
2. Pre-implementation criterion. Describe, step-by-step, the alternative interventions or techniques to be implemented, if possible, before using the PRN.
3. Procedural criterion. List the specific action to occur after the PRN is given.
4. Failure criterion. Define a level of use prompting review to determine if the PRN is excessively used or is ineffective.
5. Exit criterion. Define a time-limiting period for PRN use or a level of non-use prompting review to determine if the PRN order should be discontinued.

Probable Cause – A reasonable belief, based on reliable information, that an allegation is likely true.

Probation – Supervision of a youth who has been adjudicated delinquent by a court and who is subject to conditions imposed by the court and probation division.

Procedure – The detailed and sequential actions that must be executed to ensure that a policy is implemented. It is the method of performing an operation or a manner of proceeding on a course of action. Procedure differs from a policy in that it directs action required to perform a specific task within the guidelines of the policy.

Process – Any means (i.e., summons and complaint, subpoena) used by a court to exercise its jurisdiction over a person and/or to compel that person's attendance before it or compliance with its demands.

PSD – **See** *Placement Services Division*.

PSW – **See** *Placement Services Worker*.

PSYCHOTROPIC MEDICATION – A drug that exercises a direct effect upon the central nervous system and which is capable of influencing and modifying behavior and mental activity. Psychotropic medications include, but are not limited to, antipsychotics, antidepressants, agents for control of mania and depression, anti-anxiety agents, psychomotor stimulants, and hypnotics. (State of Tennessee DCS)

PTC – Primary treatment center

PUNISHMENT – Suffering, pain, or loss that serves as retribution; a penalty inflicted on an offender through judicial procedure; severe, rough, or disastrous treatment. (Webster)

Putative Father Registry – A register of information maintained by the central office adoption unit of those men who have submitted the required information necessary to register their intent to claim paternity of a child.

R

Rape – Sexual penetration of another accompanied by the use of force or coercion to accomplish the act.

REACT – **See** *Resource Exchange for Adoptable Children in Tennessee*

Reasonable Efforts – The department's obligation under state and federal law, and as a part of sound casework practice, to attempt risk reduction services prior to removing children from their homes. If DCS must remove the child, the court's disposition order must include documentation of the reasonable efforts that DCS exhausted in order to prevent foster care or to prove that services could not reasonably be expected to protect the child.

Records – All documents, papers, letters, maps, books, photographs, microfilms, electronic data processing files and output, films, sound recordings, or other material regardless of physical form or characteristic made or received pursuant to law or ordinance or in connection with the transaction of official business by any governmental agency.

Recording – Written documentation of each contact or attempted contact with a youth under supervision or with another individual regarding a youth under supervision. (See *Case Recordings*.)

Region – One of nine (12) geographical and administrative areas of the Tennessee Department

of Children's Services.

Release – Written authorization for delinquent youth to depart from residence at a juvenile facility and/or contract agency care.

Residential Child-Caring Agency – Any institution, society, agency, or facility, whether incorporated or not, which either primarily or incidentally provides full-time care for 13 or more children under 17 years of age outside their own homes in facilities owned or rented and operated by the organization.

RESOURCE EXCHANGE FOR ADOPTABLE CHILDREN IN TENNESSEE – The state exchange for registering approved adoptive parent(s) in partial or full guardianship.

resource Home – A private home approved by the Department of Children's Services or other licensed child-placing agency to provide full-time care for up to six (6) children at one time. This maximum includes all children in the home (birth, adopted, and foster).

Resource Parent – Any person, trained and approved by the Department of Children's Services, who provides a family home environment and care for a child in state custody in need of foster care services, kinship foster care services or adoption.

RESPITE – To provide agency foster parents or family members appropriate periods of relief from caregiving. Respite is defined as a brief break in care, with the child returning to the original placement. Respite is generally seventy-two (72) hours or less in duration unless other unique circumstances can be identified and approved.

RRMG – Regional resource management group

RUNAWAY – A child who "is away from home, residence or any other residential placement of his parent(s), guardian or other legal custodian without their consent" shall be known and defined as a "runaway." (T.C.A. 37-5-103(15)(A)(IV); DCS). DCS considers a youth who leaves without authorization and does not return within four hours as a runaway. Runaway in and of itself does not determine the level of service. Level of service is solely dependent on the overall clinical needs of the child, of which runaway behavior may be one component.

S

Safety Plan – See *Plan for Temporary Child Safety*

Sanitation – The application of measures to make environmental conditions favorable to health; the act or process of making sanitary.

SECLUSION – The placement or confinement of an individual alone in any room or area from which egress is prevented. (See DCS PPM Sect. XI. – Use of Seclusion)

Security Devices – Locks, gates, doors, bars, fences, screens, ceilings, floors, walls, and barriers used to confine and control detained individuals. Also included are electronic monitoring equipment, security alarm systems, security light units, auxiliary power supplies, and other equipment used to maintain facility security. (State of Tennessee, DCS)

SECURITY THREAT GROUP (STG) – Any organization, association, or group of persons either formal or informal that may have a common name or identifying sign or symbol and whose members or associates engage in or have engaged in activities that include, but are not limited to, planning, organizing, threatening, financing, soliciting, or committing unlawful acts. (State

of TN DCS)

Segregation – The confinement of an inmate to an individual cell that is separated from the general population. There are three forms of segregation – administrative segregation, disciplinary detention, and protective custody.

Self-Mutilation – To cut, stab, rip, burn, or otherwise damage any portion of one's own body. (DOE)

SERIOUS BODILY INJURY – An injury to the body which involves a substantial risk of death, unconsciousness, extreme physical pain, protracted and obvious disfigurement, and/or loss or impairment of the function of a member or organ of the body. (DOE)

SERVICES FOR DEVELOPMENTALLY DELAYED CHILDREN – Specialized services designed to address the developmental deficits and developmental skills needed and assistance with transitioning youth to adult services in coordination with the Department of Mental Health and Developmental Disabilities.

SEXUAL ABUSE – Sexual abuse includes penetration or external touching of a child's intimate parts, oral sex with a child, indecent exposure or any other sexual act performed in a child's presence for sexual gratification, sexual use of a child for prostitution, and the manufacturing of child pornography. Child sexual abuse is also the willful failure of the parent or the child's caretaker to make a reasonable effort to stop child sexual abuse by another person. (State of Tennessee DCS)

SEXUAL ABUSE AND SEXUAL PERPETRATION INTERVENTION AND COUNSELING – Behavioral intervention and support services to address issues related to sexual abuse and/or sexually reactive behaviors in coordination with outpatient therapy recommendations and the needs of the child and/or family.

SEXUAL ABUSE THERAPY AND SEXUAL PERPETRATION THERAPY – Therapy and intervention services to address issues related to sexual abuse and sexually reactive behaviors.

SHARED FOSTER HOME – A foster home that provides placements for more than one agency at a time.

- Between two (2) DCS contracted providers: a written agreement between the agency executive director and the DCS contract authority must be obtained. This agreement should include a delineation of each agency's responsibilities.
- Between DCS and one of its contracted providers: a written agreement between the agency executive director and the appropriate regional administrator must be obtained. This agreement should include a delineation of each agency's responsibilities. (DCS Policy 16.11)

SIR – Serious incident report

Social History – Has been replaced by the *Family Functional Assessment*. (See page 216.)

Social Service Child – A child whose main reason for being in DCS custody is other than the commission of a delinquent act.

Special Needs Child – Any child who might present a significant challenge to adoptive placement due to physical, emotional, or behavioral disabilities or by virtue of age, race, and/or sibling group. Caucasian child(ren), age nine (9) and above; African American child(ren), age three (3) and above; Child(ren) of mixed race, age three (3) and above; any race/any age sibling group of three or more children or any child(ren) who has (have) a severe physical,

emotional, or behavioral handicap(s) which would present a significant challenge to the adoptive placement.

Staffing(s) – A team composed of at least three (3) professional personnel and the youth who meet for the purpose of discussing diagnostic data, identifying problems and strengths, and formulating recommendations including the youth's placement(s).

State Fire Marshal – The official assigned to represent the state government in all matters governing fire control and safety in state operated facilities.

SUBSTANCE ABUSE COUNSELING AND INTERVENTION – Behavioral intervention and support services targeting issues related to alcohol and/or drug misuse in coordination with outpatient therapy recommendations and needs of the child and/or family.

SUBSTANCE ABUSE THERAPY – Therapy and intervention services targeting issues related to alcohol and/or drug misuse. This does not include detoxification covered by the MCO or intensive outpatient treatment (i.e., nine or more hours per week of service) covered by the BHO unless the program is designed to treat substance abusers.

Supervisor – Person to whom an employee directly reports.

Support Staff – Staff not directly providing program services to children/youth. There are two categories of support staff – *Minimum contact* - includes secretaries, clerks, computer/information resources staff, warehouse personnel, accountants and bookkeepers, personnel staff, and others who have minimal or no contact with children/youth. *Regular or Daily contact* - includes food service staff, maintenance workers, and others whose work requires day-to-day contact with children/youth.

Surrogate Parent – The person appointed by the local educational authority to serve on M-Team staffings in the place of parents who are unavailable or unwilling to participate. Resource parents are recognized as the student's parents for educational purposes provided that (1) the resource parent has had the student in care for one year and (2) manifests the intent to serve as the parent and there is not objection from any other individual claiming the right to make educational decisions for the student.

T

TennCare – TennCare is the state of Tennessee's Medicaid program that operates with special provisions for eligibility under a waiver granted by CMS (Centers for Medicare and Medicaid). TennCare is a program that provides medical assistance for certain individuals and families with low incomes and resources, as well as individuals who are uninsured or uninsurable. Individuals enrolled in TennCare are assigned to MCCs (managed care companies) who manage the administration of the benefits and coverage.

Tennessee Department of Children's Services (DCS) – The State of Tennessee Government Department that was created in July 1996 by consolidating children's services programs from six separate departments. DCS has the responsibility for protecting children from abuse and neglect, providing temporary care for children who cannot safely remain in their own homes, providing permanent homes for those children who are legally free for adoption, and rehabilitating delinquent youth through residential treatment and community-based programs.

THERAPEUTIC FOSTER CARE – High-intensity foster care that includes recruitment, training,

and support services to foster parents trained to meet the needs of youth who are appropriate for family-based care but require a higher level of behavioral intervention, case coordination, and/or counseling services. Children and foster families at this level of care require a high level of intervention, wraparound, and coordinated services to facilitate stability.

THERAPEUTIC SUPPORT SERVICES – Structured interactions used to promote social and psychological skills, including emotional self-awareness and self care, anti-anxiety techniques, anger management, communication skills and conflict resolution. Services are provided as part of therapeutic milieu, in which a supportive, structured environment advances development of emotional, social, and life skills.

THERAPY – Requires direct services in the form of individual, group, and/or family therapy and treatment planning. For programs specifically serving sex offenders, therapy must address sexual perpetration issues in addition to meeting other therapy needs. Persons providing therapy must be appropriately licensed, certified, and credentialed. They must also be appropriately supervised and follow state health care provider licensing guidelines.

THR – Temporary holding resource

THV– Trial home visit

TIMEOUT – A process in which a child or adolescent can calm down and/or self-reflect, usually by being quiet and disengaging from current stimuli. The timeout will be time-limited and may be conducted with or without removing a child from peers or the immediate area. It may be initiated at the child or staff's request or directed by staff.

TNKids – Tennessee Kids Information Data System (TNKids) is Tennessee's federally required SACWIS (Statewide Automated Child Welfare Information System) project.

Topical – A substance that is applied externally.

TPR – Termination of parental rights

Training – An organized, planned, and evaluated activity designed to achieve specific learning objectives and includes requirements for completion, attendance recording, and a system for recording completed training.

Transcript – Record of school completion by course as required by Tennessee Department of Education's Rules, Regulations, and Minimum Standards for high school graduation.

TRANSPORTATION SERVICES – Providing or coordinating transportation services to the child and/or family to ensure participation in provided services, court hearings, foster care review hearings, case-related meetings, family visits, and related services. Transportation over 250 miles per week, out-of-state visits, or out-of-state travel for reunification efforts may be supported by flex funding if recommended by the child and family team.

U

Unruly Child/Youth – A child in need of treatment and rehabilitation who habitually and without justification is truant from school while subject to compulsory schools attendance under TCA 49-6-3007; or is habitually disobedient of the reasonable and lawful commands of the child's parent(s), guardian, or other legal custodian to the degree that such child's health and safety are endangered; or commits an offense which is applicable only to a child; or is a runaway—a

child who is away from the home, residence, or any other residential placement of his parent(s), guardian, or other legal custodian without their consent.

V

Visitation – Regular contact between a child/youth and his/her parents as mandated and defined by federal foster care legislation. Any dependent/neglected, unruly, or delinquent child/youth placed in foster care must be granted an opportunity for a minimum of four (4) hours visitation each month, which may be supervised or unsupervised. Please note, however, that any visitation by delinquent youth that involves a return to the home community for a period of time and is unsupervised by program staff, requires the consent of the committing court unless the court has declined or failed to exercise the authority granted in T.C.A. §37-5-106 (4).

Volunteer – A person who contributes services to the DCS without direct monetary rewards from the DCS and shall be considered an unpaid staff member according to TCA.

WXYZ

WAIVER – A waiver is a divergence from DCS policy.

WEAPON – Any handgun, rifle, shotgun, knife, bow and arrow, and/or any other instrument which by its nature or fashion is capable of causing death or serious bodily harm. (DOE)

“‘Weapon’ means any dangerous instrument or substance that is capable of inflicting any injury on any person.” (49-6-4202(1) Education; School Security Act)

Weekend Pass – An authorized absence from a facility during the weekend lasting from at least overnight up to five days.

YDC –Youth Development Center (YDC) – A hardware secure facility that houses children who have been adjudicated delinquent and who meet the criteria as established by the department for placement at such facility. *TCA 37-5-103*